

**Request for Application 30-2020-052-DHB BH I/DD Tailored Plan**  
**Section V. Scope of Services. C and Section VI. Contract Performance**

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## V. Scope of Services. C.

### C. State-funded Services

1. Recipients
  - a. Eligibility for State-funded BH, I/DD, and TBI Services
    - i. The Department believes that establishing eligibility guidelines for State-funded Services enables the Department and the BH I/DD Tailored Plans to:
      - a) Target State-funded Services to populations with low and modest incomes and/or who need specialized services that are not otherwise available to them;
      - b) Encourage uninsured State-funded Services potential recipients to apply for Medicaid to obtain comprehensive insurance coverage; and
      - c) Maximize the impact of limited state funds available for behavioral health and I/DD services by ensuring other available coverage and payments sources are pursued.
    - ii. Upon BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan may choose to use the following eligibility guidelines for State-funded BH, I/DD, and TBI services established by the Department:
      - a) BH Services:
        1. Income:  $\leq 300\%$  of the federal poverty level; and
        2. Insurance Status/Other Financial Resources:
        3. Uninsured, or insured with third-party insurance (including Medicaid) that:
          - a) Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; or
          - b) Covers the State-funded SUD service, but associated cost-sharing is unaffordable.
        4. BH I/DD Tailored Plans shall encourage non-Medicaid covered potential recipients to apply for Medicaid coverage.
      - b) I/DD and TBI Services:
        1. Income: no specified limits
        2. Insurance Status/Other Financial Resources:
        3. Uninsured; or
        4. Third-party coverage, including Medicaid, that does not cover the State-funded service, and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; and
        5. Applied for Medicaid coverage.
    - iii. NC Medicaid and NC Health Choice beneficiaries who are members of Standard Plans are ineligible to obtain State-funded Services.
    - iv. In recognition of the BH I/DD Tailored Plan's knowledge of its recipients' needs and other resources available throughout its catchment, the Department shall permit the BH I/DD Tailored Plan to propose its own eligibility criteria for State-funded Services.
    - v. The BH I/DD Tailored Plan shall include a proposal for eligibility for State-funded Services in the Applicant's Application for the Department's review and approval.
    - vi. The BH I/DD Tailored Plans will be required to solicit feedback from their Consumer and Family Advisory Committee (CFAC) on their proposed State-funded Services eligibility criteria.
    - vii. When approved by the Department, the Department shall amend the BH I/DD Tailored Plan's contract to reflect the eligibility criteria.
    - viii. The BH I/DD Tailored Plan shall not impose eligibility criteria on behavioral health crisis services, including detoxification services listed in *Section V.C.2 Table 1: Required State-funded BH, I/DD, and TBI Services*.

- ix. The Department reserves the right to require standard eligibility criteria for State-funded Services across the State in the future.
  - x. The Department may instruct the BH I/DD Tailored Plan waive any of its eligibility criteria in the case of supporting the State’s coordinated response to a disaster or state of emergency.
  - xi. Recipient Eligibility Policy for State-funded Services
    - a) The BH I/DD Tailored Plan shall submit a Recipient Eligibility Policy for State-funded Services to the Department for review and approval one hundred fifty (150) Calendar Days after Contract Award. The BH I/DD Tailored Plan must submit an updated version of the Recipient Eligibility Policy for State-funded Services sixty (60) calendar days prior to BH I/DD Tailored Plan launch and at the beginning of each contract year.
    - b) The Recipient Eligibility Policy for State-funded Services shall include the BH I/DD Tailored Plan’s:
      1. Final eligibility criteria;
      2. Processes and procedures for:
      3. Implementing final eligibility criteria including the role of providers in implementation;
      4. Monitoring the implementation of the final eligibility criteria;
      5. Supporting a potential recipient in applying for available other coverage; and
      6. Collecting and reporting eligibility criteria to the Department.
  - xii. Waiting List for State-funded Services
    - a) The BH I/DD Tailored Plan shall develop and maintain a waiting list for individuals waiting for any State-funded BH, I/DD or TBI service that is organized by the following disability groups:
      1. All disability
      2. Adult mental health
      3. Child/adolescent mental health
      4. Adult SUD
      5. Child/adolescent SUD
      6. I/DD
      7. TBI
    - b) By BH I/DD Tailored Plan launch, the Department plans to develop a system to maintain and aggregate a statewide waiting list for individuals waiting for any State-funded BH, I/DD or TBI service across all BH I/DD Tailored Plans.
    - c) Upon the launch of the statewide waiting list, the BH I/DD Tailored Plan shall report its waiting list to the Department in a format and frequency to be specified by the Department.
    - d) The BH I/DD Tailored Plan shall ensure that its contracted providers report their waiting lists, by both disability group (e.g., SUD, MH, I/DD or TBI) and by specific service type, to the BH I/DD Tailored Plan on a monthly basis.
    - e) The BH I/DD Tailored Plan shall provide interim services as defined by 42 CFR 96.121 and 42 CFR 96.126 for individuals who are pregnant and using substances and individuals who are injecting drugs who are on waiting lists for SUD services until services that meet the individual’s level of need are available. These individuals are priority populations under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).
- b. Recipient Engagement
- i. Recipients, their families, and caregivers may need support from the BH I/DD Tailored Plan providers and the Department in order to benefit fully as recipients of State-funded Services. The BH I/DD Tailored Plan will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting recipients and their families with understanding State-funded Services, navigating the health care system, improving overall recipient health through various avenues including maintaining a Recipient Services Department, and conducting recipient and community engagement and outreach. The Department strongly

- encourages the BH I/DD Tailored Plan to develop innovative approaches, including the use of electronic mechanisms for recipient education, engagement, and outreach.
- ii. The BH I/DD Tailored Plan shall be responsible for engaging recipients of State-funded Services and their Authorized Representatives and providing assistance with understanding State-funded Services and recipients rights and responsibilities. Information shall be available and provided to recipients in-person, by telephone, by mail, and online/electronically.
  - iii. The BH I/DD Tailored Plan shall utilize various engagement strategies and communication mediums to engage, educate, and assist recipients. The engagement strategy shall include the operation of a Recipient Services Department which, at a minimum, shall:
    - a) Maintain a recipient call center and a recipient services website;
    - b) Engage with the Department's Recipient's Engagement and Customer Services offices, as well as local community and county organizations in the recipient's service area;
    - c) Provide written and in-person educational materials, activities, and programs;
    - d) Collaborate with other entities operating within the State-funded Services delivery system; and
    - e) Comply with requirements of *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan delegates any of the requirements to a Subcontractor.
  - iv. The BH I/DD Tailored Plan may operate its recipient engagement activities utilizing shared staffing and infrastructure with its Medicaid member engagement activities.
  - v. Recipient Services Department
    - a) The BH I/DD Tailored Plan shall have and implement recipient services policies and procedures that address all recipient services activities.
    - b) The BH I/DD Tailored Plan shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to recipients in accordance with translation and interpreter services requirements in the Contract to achieve effective communication.
    - c) The recipient services staff shall be responsible, at a minimum, for the following functions:
      1. Explaining operation of the BH I/DD Tailored Plan and what to do in an emergency, disaster or urgent medical situation;
      2. Educating and assisting recipients with determining eligibility and obtaining State-funded Services for which they are eligible;
      3. Explaining care management services offered by the BH I/DD Tailored Plan;
      4. Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
      5. Fielding and responding to recipients' questions and complaints;
      6. Clarifying for recipients information in the Recipient Handbook;
      7. Advising recipients of and assisting recipients with the appeals, complaints, and State Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Appeals Panel processes;
    - d) The BH I/DD Tailored Plan shall operate and maintain the following two (2) recipient-facing service lines:
      1. Member and Recipient Service Line (see V.A.2.a. Service Lines for Medicaid and State-funded Services ); and
      2. Behavioral Health Crisis Line (see V.A.2.a. Service Lines for Medicaid and State-funded Services)
    - e) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Recipient Services Department via surveys of recipients of State-funded Services and internal audits of departments to ensure recipient satisfaction and compliance with applicable performance standard metrics as specified in the Contract and shall take corrective action as necessary.

1. Recipient surveys shall be made available after each web, call center (with exception of BH Crisis Line) or in-person interaction.
  2. Surveys and internal audits are intended to measure the recipient's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
  3. Reports, including the results of provider surveys and the BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- vi. Recipient Services Website
- a) The Department encourages the BH I/DD Tailored Plan to utilize processes, procedures and technology to improve the recipient experience and effectively reduce or ease administrative burdens on the recipient.
  - b) The BH I/DD Tailored Plan shall develop and maintain a State-funded Services website that, at a minimum, has the functionality to allow the recipient to search for in-network providers. The Recipient Services website may be a part of the BH I/DD Tailored Plan's Medicaid website.
  - c) The BH I/DD Tailored Plan shall also include on its website within two (2) "clicks" from the homepage, at a minimum:
    1. An up-to-date copy of the Recipient Handbook;
    2. Information on hours of operation;
    3. How to contact the recipient services staff;
    4. How to access BH I/DD Tailored Plan services;
    5. Appeals, complaints, and State MH/DD/SA Appeals Panel;
    6. Health promotion and educational materials;
    7. Any specific prevention or care management programs offered by the BH I/DD Tailored Plan;
    8. Information relevant to any disasters or states of emergency affecting the BH I/DD Tailored Plan region; and Other information the BH I/DD Tailored Plan believes would support the recipient and their families.
  - d) The BH I/DD Tailored Plan shall meet the same literacy standards identified for written materials in any materials made available electronically.
  - e) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
  - f) The BH I/DD Tailored Plan website shall be accessible via mobile devices.
  - g) The BH I/DD Tailored Plan website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's systems that impact the ability for the website to operate correctly.
    1. The BH I/DD Tailored Plan shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
    2. The BH I/DD Tailored Plan shall notify the Department of unscheduled downtime within one (1) hour and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the BH I/DD Tailored Plan.
- vii. Communications with Recipients and Potential Recipients
- a) The BH I/DD Tailored Plan shall ensure all contacts with recipients and Authorized Representatives are Culturally and Linguistically Competent and provide effective communication, with deference to the method requested by the recipient, to the recipient,

including sign language interpreters, and occur in a timely manner that protects the privacy and independence of an individual with a disability.

- b) The BH I/DD Tailored Plan shall ensure that recipients and potential recipients are provided all information required in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
  - c) The BH I/DD Tailored Plan shall address the following in the development of recipient materials:
    - 1. The population size and geographic/regional needs and differences throughout the BH I/DD Tailored Plan's Region;
    - 2. Language proficiencies;
    - 3. Types of disabilities;
    - 4. Literacy levels;
    - 5. Cultural needs of the recipient population;
    - 6. Age and age-specific or other targeted learning skills or capabilities; and
    - 7. Ability to access and use technology.
  - d) The BH I/DD Tailored Plan shall be permitted to provide information required to be communicated to recipients and potential recipients in the following manner:
    - 1. Mailing a printed copy of the information to the recipient's mailing address is the default absent an explicit preference stated by the recipients or their Authorized Representative;
    - 2. Emailing the information, after receiving the recipient's or potential recipient's express consent to receive information via email and obtaining a valid, up to date email address;
    - 3. Posting the information on the BH I/DD Tailored Plan's website and advising the recipient or potential recipient in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a recipient may request communication accommodations; and
    - 4. Providing the information by any other method that can reasonably be expected to result in the recipient receiving the information.
  - e) The BH I/DD Tailored Plan shall not construe any requirement herein to limit or alleviate the BH I/DD Tailored Plan's obligation to communicate directly with the recipient, a recipient's Authorized Representative, parent or guardian, or potential recipient as required under the Contract or under federal or state law or regulation.
  - f) The BH I/DD Tailored Plan shall provide information in the recipient's preferred format upon request at no cost (e.g., a recipient with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
  - g) The BH I/DD Tailored Plan shall consult with and comply with practices of the Department's Office of Communications, including Creative Services.
- viii. Written and Verbal Recipient Materials
- a) The BH I/DD Tailored Plan shall provide all written materials to recipients and potential recipients consistent with the following:
    - 1. Use easily understood language and format.
    - 2. Use a san serif font type and a font size no smaller than 12-point. The font type and size shall be appropriate to the audience.
    - 3. Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of recipients or potential recipients with disabilities or limited English proficiency.
    - 4. Include a large print (i.e., font size no smaller than eighteen (18) point) tagline and information on how to request auxiliary aids and services, including materials in alternative formats.
    - 5. Written in accordance with Associated Press Style and Department-specific style guide.

6. Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
  7. Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the BH I/DD Tailored Plan's Member and Recipient Service Line. The top fifteen (15) prevalent non-English languages in North Carolina include:
    8. Spanish,
    9. Chinese (Mandarin Simplified),
    10. Vietnamese,
    11. Korean,
    12. French,
    13. Arabic,
    14. Hmong,
    15. Russian,
    16. Tagalog,
    17. Gujarati,
    18. Mon-Khmer (Cambodia),
    19. German,
    20. Hindi,
    21. Laotian, and
    22. Japanese.
  - b) The BH I/DD Tailored Plan shall ensure that all audio-reliant materials (e.g., videos, webinars, and recorded presentations) have accessible captioning at the time they are made available to recipients in their original format.
  - c) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
  - d) The BH I/DD Tailored Plan shall ensure that all written materials made available electronically are accessible on various platforms, such as website and mobile devices.
- ix. Mailing Materials to Recipients
- a) The BH I/DD Tailored Plan shall verify addresses against a United States Postal Service approved product or service on all recipients of State-funded Services through BH I/DD Tailored Plan prior to mailing materials, at no additional cost to the Department or the recipient.
    1. The BH I/DD Tailored Plan shall make all reasonable attempts to identify the correct mailing address and mail information to the recipient within applicable timeframes, as required under the Contract.
    2. The BH I/DD Tailored Plan shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
    3. The BH I/DD Tailored Plan shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
  - b) The BH I/DD Tailored Plan shall notify the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.
  - c) If the BH I/DD Tailored Plan identifies a new, updated address, the BH I/DD Tailored Plan shall resend only recipient specific information at no additional cost to the Department or the recipient.
  - d) All materials mailed to potential recipients, recipients, and, when applicable, Authorized Representatives, shall be sent via first class mail.

- e) The BH I/DD Tailored Plan shall consider cost-effective methods for controlling postage costs when producing recipient materials for mailing.
  - f) The BH I/DD Tailored Plan shall develop a Member and Recipient Mailing Policy, subject to Department review and approval. The BH I/DD Tailored Plan shall submit to the Department ninety (90) Calendar Days after Contract Award.
- x. Translation and Interpretation Services
- a) The BH I/DD Tailored Plan shall make interpretation services available to all potential recipients and recipients for interactions between the BH I/DD Tailored Plan and potential recipients or recipients. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent.
  - b) The BH I/DD Tailored Plan shall notify its recipients of the availability of interpretation services and inform them of how to access such services, including providing the following information:
    1. That verbal information is available for any language and written translation is available in prevalent languages free of charge to each recipient; and
    2. That auxiliary aids and services are available upon request and at no cost for recipients with disabilities.
  - c) The BH I/DD Tailored Plan shall offer qualified interpreter services for verbal contacts with recipients and Authorized Representatives whose primary language is not English.
  - d) The BH I/DD Tailored Plan shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
  - e) The BH I/DD Tailored Plan shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with recipient audiences.
  - f) The BH I/DD Tailored Plan shall make interpretation services available free of charge to each recipient.
  - g) The BH I/DD Tailored Plan shall staff recipient facing Member and Recipient and BH Crisis Service Lines with a sufficient number of fluent Spanish speakers to converse with recipients who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the recipient or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department.
  - h) Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:
    1. Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
    2. Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
  - i) The BH I/DD Tailored Plan shall notify the Department in writing within five (5) Business Days each time the BH I/DD Tailored Plan or its Subcontractor charges a recipient, potential recipient, Authorized Representative or guardian for interpreter or translation services.
  - j) The BH I/DD Tailored Plan shall notify the Department of any change in the language preference for recipients in an electronic format and frequency as defined by the Department.
- xi. Recipient Welcome Packet
- a) The BH I/DD Tailored Plan shall send a Welcome Packet to the recipient within eight (8) Calendar Days after the BH I/DD Tailored Plan receives notice of recipient's first service use. On an annual basis, the BH I/DD Tailored Plan shall verify if the recipient continues to use State-funded Services:
    1. If the recipient continues to use State-funded Services, the BH I/DD Tailored Plan shall send a Welcome Packet; and

2. If the recipient does not continue to use State-funded Services, the BH I/DD Tailored Plan shall not send a Welcome Packet and shall not have an obligation to verify if the recipient continues to use State-funded Services thereafter.
- b) The BH I/DD Tailored Plan shall include the following in the recipient Welcome Packet:
    1. A welcome letter that provides the following information to the recipient:
    2. The toll-free service line numbers which a recipient may call for the Member and Recipient Service Line and BH Crisis Line;
    3. Information on how to inquire about accessing care management services; and
    4. A current Recipient Handbook.
  - c) The BH I/DD Tailored Plan may opt to send the handbook separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
  - d) The BH I/DD Tailored Plan shall submit a sample copy of the contents of its Recipient Welcome Packet to the Department for review and approval within ninety (90) Calendar Days of Contract Award, and then annually thereafter.
  - e) All materials mailed to potential recipients, and when applicable, Authorized Representatives, shall be sent via first class mail, unless otherwise approved by the Department through the Recipient Mailing Policy.
- xii. Recipient Handbook
- a) The BH I/DD Tailored Plan shall ensure that each recipient receives a Recipient Handbook, which provides a summary of services, within eight (8) Calendar Days after the BH I/DD Tailored Plan receives notice that the recipient is receiving State-funded Services through the BH I/DD Tailored Plan.
  - b) The BH I/DD Tailored Plan shall use the Department's forthcoming guidance to develop the Recipient Handbook.
  - c) The BH I/DD Tailored Plan shall ensure that all Recipient Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
  - d) The BH I/DD Tailored Plan shall ensure that the Recipient Handbook includes sufficient information that enables the recipient to understand how to effectively use State-funded Services. This information shall include at a minimum:
    1. Covered services provided by the BH I/DD Tailored Plan.
    2. Waiting list policies for covered services.
    3. Procedures for obtaining services, including any requirements for service authorizations and/or referrals for specialty care.
    4. Information on how to access case management services and care management delivered through the BH I/DD Tailored Plan.
    5. Information on services offered for recipients residing in institutional settings or adult care homes for recipients with SMI related to housing and community integration.
    6. Recipient rights and responsibilities, including the elements specified under the Contract.
    7. Complaint, appeal, and State MH/DD/SA Appeals Panel procedures and timeframes developed or approved by the Department, including information on:
      8. The right to file complaints and appeals;
      9. The requirements and timeframes for filing a complaint or appeal or State MH/DD/SA Appeals Panel Hearing;
      10. The availability of assistance in the filing process;
      11. The right to request a State MH/DD/SA Appeals Panel after the BH I/DD Tailored Plan makes a decision on the recipient's appeal which is adverse to the recipient.
    12. How to exercise an Advance Directive.

13. An overview of its continuation of services policy and define when, why, and how a recipient or a recipient's Authorized Representative may file for a continuation of services.
  14. How to access auxiliary aids and services, including additional information in alternative formats or languages.
  15. The toll-free help line numbers for the Member and Recipient Service Line and BH Crisis Line.
  16. Information on how to report suspected fraud, waste or abuse.
  17. Information about the BH I/DD Tailored Plan's prevention health programs.
- e) The BH I/DD Tailored Plan shall make the Recipient Handbook available for review by the Department, upon request.
  - f) The BH I/DD Tailored Plan shall provide the Department for review any changes to the Recipient Handbook forty-five (45) Calendar Days prior to the intended effective date of the change.
- xiii. Recipient Education and Outreach
- a) The BH I/DD Tailored Plan shall provide education and outreach to recipients and potential recipients, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department may be present.
  - b) The BH I/DD Tailored Plan shall provide information regarding its planned recipient education efforts to the Department for review and approval sixty (60) Calendar Days after Contract Award and annually thereafter.
- xiv. Health Education and Promotion Programs
- a) The BH I/DD Tailored Plan shall develop recipient health education and promotion programs that address prevention and wellness from illness and disease.
  - b) The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care.
  - c) The BH I/DD Tailored Plan shall make the health education and promotion programs available to recipients through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
  - d) The Department may select specific educational and health promotion topics for the BH I/DD Tailored Plan to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- c. Marketing
- i. The Department views BH I/DD Tailored Plan marketing activities as a method to help publicize State-funded Services, while ensuring the protection of recipients from coercive or misleading practices.
  - ii. The BH I/DD Tailored Plan shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the BH I/DD Tailored Plan to ensure that recipients receive accurate verbal and written information.
  - iii. The BH I/DD Tailored Plan shall not market nor distribute any marketing materials without obtaining written approval from the Department. Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
  - iv. The BH I/DD Tailored Plan shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud recipients or the Department.
  - v. The BH I/DD Tailored Plan shall establish and maintain a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented shall be the responsibility of the BH I/DD Tailored Plan.

- vi. If the BH I/DD Tailored Plan chooses to market, the BH I/DD Tailored Plan shall distribute marketing materials to the entire Region served by the BH I/DD Tailored Plan.
- vii. The BH I/DD Tailored Plan shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the recipient materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- viii. The BH I/DD Tailored Plan shall ensure that all marketing materials and marketing strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy. In addition, the BH I/DD Tailored Plan shall not discriminate against recipients or potential recipients who may:
  - a) Live or receive health care in rural or underserved areas; or
  - b) Experience income disparities.
- ix. The BH I/DD Tailored Plan shall assign a unique marketing code to all marketing materials distributed to recipients.
- x. Marketing Materials and Activities
  - a) Permissible Marketing Activities
    - 1. The BH I/DD Tailored Plan may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
    - 2. The BH I/DD Tailored Plan shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
    - 3. The BH I/DD Tailored Plan may participate in community-based marketing events or activities (e.g., health fairs, community events).
    - 4. The BH I/DD Tailored Plan may sponsor outreach activities and events, including as a financial sponsor.
    - 5. The BH I/DD Tailored Plan may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
    - 6. The BH I/DD Tailored Plan may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
  - b) Prohibited Statements, Claims, and Activities (Written or Oral)
    - 1. The BH I/DD Tailored Plan shall not claim that the BH I/DD Tailored Plan is endorsed by SAMHSA, the federal or State government, or similar entity.
    - 2. The BH I/DD Tailored Plan shall not use the Department or State logo or other proprietary material in marketing.
    - 3. The BH I/DD Tailored Plan shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
    - 4. The BH I/DD Tailored Plan shall not reference competing BH I/DD Tailored Plans or other contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department or other BH I/DD Tailored Plans in any of its marketing materials.
    - 5. The BH I/DD Tailored Plan shall not cross-market with a Standard Plan.
    - 6. The BH I/DD Tailored Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities, including direct mailings and solicitation.
    - 7. The BH I/DD Tailored Plan shall not falsely describe available services, availability of network providers, or qualifications or skills of network providers.

8. The BH I/DD Tailored Plan shall not market materials or activities that are discriminatory
  9. The BH I/DD Tailored Plan shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
  10. The BH I/DD Tailored Plan shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
  11. The BH I/DD Tailored Plan shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
- c) References to Studies and Statistics
1. The BH I/DD Tailored Plan shall not use irrelevant facts or inaccurate statistical information in any marketing materials and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
  2. If references to a study or statistics are included in any marketing material, the BH I/DD Tailored Plan shall provide reference information (e.g., publication, date, page number) and information about the BH I/DD Tailored Plan's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.
- xi. Department Approval of Marketing Materials
- a) The BH I/DD Tailored Plan shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.
  - b) If the BH I/DD Tailored Plan makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the BH I/DD Tailored Plan must resubmit the materials, in accordance with this section, for Department review and approval.
- xii. The BH I/DD Tailored Plan shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the BH I/DD Tailored Plan's marketing activities in accordance with *Section VI. Contract Performance for Medicaid and State-funded Services*.
- d. Recipient Rights and Responsibilities
- i. The Department expects the BH I/DD Tailored Plan to treat recipients with dignity and respect, to protect recipients' rights, to inform recipients of their responsibilities as recipients of State-funded Services, and ensure each recipient is not subject to any unlawful discrimination in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any Network provider of the BH I/DD Tailored Plan.
  - ii. The BH I/DD Tailored Plan shall establish and maintain written policies and procedures that are designed to protect the rights of recipients and describe the responsibilities of each recipient. The BH I/DD Tailored Plan shall develop and submit to the Department for review a Member and Recipient Rights and Responsibilities Policy ninety (90) Calendar Days after Contract Award.
  - iii. The BH I/DD Tailored Plan shall include a written description of the rights and responsibilities of recipients in the Recipient Welcome Packet and the Recipient Handbook.
  - iv. The BH I/DD Tailored Plan shall provide a copy of its Member and Recipient Rights and Responsibilities Policy to all BH I/DD Tailored Plan employees and Network providers.
  - v. The BH I/DD Tailored Plan shall ensure its written policies and procedures, at a minimum, afford recipients the right to:
    - a) Receive information in a manner and format that may be easily understood and is readily accessible;
    - b) Be treated with respect and with due consideration for their dignity and privacy;
    - c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the recipient's condition and ability to understand;

- d) Participate in decisions regarding their health care, including the right to refuse treatment;
  - e) Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
  - f) If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
  - g) Be furnished, consistent with the Scope of Services of this Contract.
- vi. The BH I/DD Tailored Plan shall not attempt to influence, limit, or otherwise interfere with the recipient's decision to exercise his or her rights as provided in this Contract.
  - vii. The BH I/DD Tailored Plan shall ensure that recipients are free to exercise their rights and that the exercise of those rights does not adversely affect the way the BH I/DD Tailored Plan or its Network providers treat the recipient.
  - viii. The BH I/DD Tailored Plan shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against recipients in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any network provider of the BH I/DD Tailored Plan.
- e. Recipient Complaints and Appeals
    - i. The Department is committed to ensuring that recipients understand and can freely exercise their complaints and appeals rights and resolve issues efficiently with minimal burden to the recipient or their Authorized Representative. The BH I/DD Tailored Plan shall educate the recipient on their rights and provide reasonable assistance with understanding and navigating the complaints and appeals processes.
    - ii. Recipient Complaints and Appeals General Requirements
      - a) The BH I/DD Tailored Plan shall establish and maintain a complaints and appeals system for reviewing and resolving recipient complaints and appeals for State-funded Services as required in 10A NCAC 27G.7000 and 10A NCAC 27I.0600. Components of the system shall include a complaint and plan level appeal process for recipients of State-funded Services, a plan level appeal process for utilization review decisions to deny, reduce, suspend, or terminate State-funded Services, and access to the State MH/DD/SA Appeals Panel under N.C. GEN. STAT. § 122.C – 151.4.
      - b) The BH I/DD Tailored Plan shall, while adhering to the required Utilization Management Program, employ strategies to resolve complaint and appeals at lowest level of escalation that meets a recipient's needs and in a manner that does not discourage recipients from exercising their rights. The BH I/DD Tailored Plan shall provide recipients reasonable assistance in completing forms and taking other procedural steps related to a complaint or appeal including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability.
      - c) The BH I/DD Tailored Plan shall establish complaints procedures as per 10A NCAC 27G.7001 – 7004, 10A NCAC 27G.0601 – 0608 and 27G.0810-0812.
    - iii. Recipient Complaint Process
      - a) The BH I/DD Tailored Plan shall develop and maintain a Recipient Complaint Policy following the process outlined in 10A NCAC 27G.7002. The Recipient Complaint Policy is subject to Department review and approval.
      - b) The BH I/DD Tailored Plan shall allow a recipient or Authorized Representative to file a complaint with the BH I/DD Tailored Plan, verbally or in writing, at any time.
      - c) The BH I/DD Tailored Plan's recipient complaint process shall include acknowledgement, in writing, within five (5) Business Days of receipt of each complaint. This communication shall include whether the complaint will be addressed informally or by conducting an investigation.

- d) The BH I/DD Tailored Plan shall use the Department-defined Notice of Acknowledgement of Receipt of Complaint to notify the recipient of receipt of the complaint.
  - e) For an informal process, the BH I/DD Tailored Plan shall provide written notice of resolution of the complaint to the recipient and, as applicable, the recipient's Authorized Representative within fifteen (15) Business Days from the date the BH I/DD Tailored Plan receives the complaint.
  - f) For a formal investigation, the BH I/DD Tailored Plan shall complete the investigation within thirty (30) Calendar Days from the date the BH I/DD Tailored Plan receives the complaint. Upon completion of the investigation, the BH I/DD Tailored Plan shall submit a written report of the findings within fifteen (15) Calendar Days of the date of completion of the report. 10A NCAC 27G.7003.
  - g) The BH I/DD Tailored Plan shall adhere to the complaint requirements detailed in *Section VII. Attachment N. Addendum for Division of State Operated Healthcare Facilities* for grievances filed by recipients obtaining services in DSOHF facilities.
- iv. Internal Plan Appeals for Provision of State-funded Services
- a) The BH I/DD Tailored Plan shall have an established internal recipient appeal process for the provision of State-funded Services per 10A NCAC 27G.7002.
  - b) If the complainant is not satisfied with the informal process, the complainant may file an appeal in writing to the BH I/DD Tailored Plan. The appeal must be received within fifteen (15) Business Days from the date of the informal resolution letter.
  - c) The BH I/DD Tailored Plan Behavioral Health Director or designee shall convene an appeal review committee according to 10A NCAC 27G.7002(b)(3)(J) and issue an independent decision after reviewing the appeal review committee's recommendation. The decision shall be dated and mailed to the appellant by the BH I/DD Tailored Plan within twenty (20) Business Days from receipt of the appeal.
  - d) When the BH I/DD Tailored Plan refers the complaint to the State or local government agency responsible for the regulation and oversight of the provider, the BH I/DD Tailored Plan shall send a letter to the complainant informing him or her of the referral and the contact person at the agency where the referral was made. The BH I/DD Tailored Plan shall contact the State or local government agency where the referral was made within eighty (80) Business Days of the date the BH I/DD Tailored Plan received the complaint to determine the actions the State or local government agency has taken in response to the complaint. The BH I/DD Tailored Plan shall communicate the status of the State or local government agency's response to the complainant and to the client's home BH I/DD Tailored Plan, if different.
- v. Internal Plan Appeals for Utilization Review Decisions
- a) The BH I/DD Tailored Plan shall have an established internal recipient appeal process for utilization review decisions to deny, reduce suspend, or terminate a State-funded Services as outlined under 10A NCAC 2G.7004.
  - b) Notice of Adverse Utilization Review Decisions
    1. The BH I/DD Tailored Plan shall send to the recipient or Authorized Representative(s) notification letters regarding utilization review decisions for State-funded Services. The letter shall be dated and mailed no later than the next work day following the review decision to deny, reduce, suspend, or terminate a State-funded Service.
    2. The letter shall include information regarding the reason for the decision and any available options or considerations while the appeal is under review.
    3. An appeal regarding a State-funded Services utilization review decision must be filed only by a recipient or Authorized Representative. The appeal must be received in writing by the BH I/DD Tailored Plan within fifteen (15) Business Days of the date of the notification letter.

4. The BH I/DD Tailored Plan shall acknowledge receipt of the appeal in writing in a letter to the appellant dated the next working day after receipt of the appeal.
  5. The BH I/DD Tailored Plan may authorize interim services until the final review decision, as set forth in 10A NCAC 271 .0609, is reached.
  6. The clinical review shall be conducted by an employee(s) or contractor(s) of the BH I/DD Tailored Plan not involved in the utilization review decision that is the subject of the appeal. The clinical reviewer(s) clinical credentials shall be at least comparable to those of the person who rendered the initial utilization review decision.
  7. The clinical reviewer(s) shall complete a clinical review of the appeal and shall uphold or overturn the original decision.
  8. The BH I/DD Tailored Plan shall notify the appellant in writing of the clinical review decision in a letter dated and mailed within seven (7) Business Days from receipt of the appeal request and shall separately notify the provider regarding the service authorization.
  9. If the clinical review overturns the initial utilization review decision, the decision letter shall state the date on which the denied service shall be authorized or the date on which the suspended, reduced or terminated service shall be reinstated.
  10. In cases in which the decision upholds the previous decision, the BH I/DD Tailored Plan shall inform appellants in writing of the opportunity to appeal a decision regarding a State-funded service to the DMH/DD/SAS Non-Medicaid Appeals Panel according to 10A NCAC 271 .0600 and N.C. Gen. Stat. § 143B-147(a)(9).
- vi. State Non-Medicaid Appeals Panel
- a) The BH I/DD Tailored Plan shall comply with 10A NCAC 271 .0600 and N.C. Gen. Stat. § 143B-147(a)(9), and Department guidance related to the State Non-Medicaid Appeals Panel.
  - b) Upon receipt of the panel's findings and decisions, the BH I/DD Tailored Plan shall issue a final decision informed by these findings. The BH I/DD Tailored Plan shall issue the decision in writing within ten (10) Calendar Days of receipt of the panel's findings and decisions.
  - c) Neither the panel findings and decisions nor the BH I/DD Tailored Plan decision shall be interpreted as an agency decision granting a recipient the right to appeal by requesting a contested case hearing pursuant to Chapter 150B of the General Statutes.

## 2. Services

### a. State-funded BH, I/DD and TBI Services

- i. The BH I/DD Tailored Plan shall promptly provide, arrange, purchase or otherwise make available all medically necessary BH, I/DD and TBI services required under this Contract to all its recipients, subject to available funding as determined by the Department. Services shall be delivered consistent with the standard of care and meet Department quality standards and expectations.
- ii. The BH I/DD Tailored Plan shall provide all State-funded BH, I/DD and TBI services listed in this Contract subject to available resources.
- iii. Nothing in this Contract shall be construed or interpreted as creating an entitlement to non-Medicaid services.
- iv. Covered services:
  - a) Consistent with N.C. Gen. Stat. § 108D-60(9), the BH I/DD Tailored Plan shall be responsible for covering state appropriated and block grant funded non-Medicaid BH, I/DD and TBI services subject to available resources, as determined by the Department.
  - b) The BH I/DD Tailored Plan shall authorize and fund the medically necessary BH, I/DD and TBI core services listed in *Section V.C.2. Table 1: State-funded BH, I/DD, and TBI Services* according to the Department approved service definitions subject to available funding, as determined by the Department.

- c) The BH I/DD Tailored Plan may authorize and fund medically necessary BH and I/DD non-core services listed in *Section V.C.2. Table 1: State-funded BH, I/DD, and TBI Services* according to the Department approved service definitions subject to available funding, as determined by the Department.
- d) The Department shall retain the right to promulgate new policy and changes to policy as appropriate.
- e) A crosswalk of the SUD services covered under the State-funded Services array to national clinical standards is provided in *Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to Covered State-funded SUD Services*.

<b>Section V.C.2 Table 1: State-funded BH, I/DD, and TBI Services</b>		
<b>Disability Group</b>	<b>Core Services</b>	<b>Non-Core Services</b>
All-Disability	<ol style="list-style-type: none"> <li>1. Diagnostic assessment<sup>1</sup></li> <li>2. Facility based crisis for adults<sup>2</sup></li> <li>3. Inpatient BH services, including 3-way contract beds</li> <li>4. Mobile crisis management</li> <li>5. Outpatient services<sup>3</sup></li> </ol>	<ol style="list-style-type: none"> <li>1. BH urgent care</li> <li>2. Facility based crisis for children and adolescents</li> </ol>
Adult Mental Health	<ol style="list-style-type: none"> <li>1. Assertive community treatment (ACT)<sup>4</sup></li> <li>2. Assertive engagement</li> <li>3. Case management<sup>5</sup></li> <li>4. Community support team (CST)</li> <li>5. Peer supports<sup>6</sup></li> <li>6. Psychosocial rehabilitation</li> <li>7. Mental health recovery residential services<sup>7</sup></li> <li>8. Individual placement and support-supported employment (IPS-SE)<sup>8</sup></li> <li>9. Transition management service</li> </ol>	<ol style="list-style-type: none"> <li>1. Partial hospitalization</li> </ol>

<sup>1</sup> Diagnostic assessment may be provided through Telehealth.

<sup>2</sup> This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

<sup>3</sup> The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

<sup>4</sup> The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

<sup>5</sup> This service may include critical time intervention, case management, and resource intensive case management (RICM).

<sup>6</sup> Peer supports include individual and group services.

<sup>7</sup> This category of services may include group living and supervised living among other services.

<sup>8</sup> The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at:

<https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364>

**Section V.C.2 Table 1: State-funded BH, I/DD, and TBI Services**

Disability Group	Core Services	Non-Core Services
Child Mental Health	<ol style="list-style-type: none"> <li>1. High fidelity wraparound (HFW)<sup>9</sup></li> <li>2. Respite</li> </ol>	<ol style="list-style-type: none"> <li>1. Intensive in-home</li> <li>2. Mental health day treatment</li> <li>3. Multi-systemic therapy</li> </ol>
I/DD and TBI <sup>10</sup>	<ol style="list-style-type: none"> <li>1. Meaningful day and prevocational services<sup>11</sup></li> <li>2. Residential services<sup>12</sup></li> <li>3. TBI long term residential rehabilitation services</li> <li>4. Supported employment<sup>13</sup></li> <li>5. Respite</li> </ol>	N/A
Substance Use Disorder	<ol style="list-style-type: none"> <li>1. Ambulatory detoxification</li> <li>2. Assertive engagement</li> <li>3. Case management<sup>14</sup></li> <li>4. Clinically managed population specific high intensity residential services<sup>15</sup></li> <li>5. Outpatient opioid treatment</li> <li>6. Non-hospital medical detoxification</li> <li>7. Peer supports<sup>16</sup></li> <li>8. Substance use residential services and supports<sup>17</sup></li> <li>9. Substance abuse halfway house</li> <li>10. Substance abuse comprehensive outpatient treatment</li> <li>11. Substance abuse intensive outpatient program</li> </ol>	<ol style="list-style-type: none"> <li>1. Social setting detoxification services</li> </ol>

<sup>9</sup> The Department intends allocate funding for slots for HFW services.

<sup>10</sup> I/DD and TBI care management will be only be provided by the BH I/DD Tailored Plan.

<sup>11</sup> This category of services may include day supports, adult developmental vocational program, personal assistance and developmental day among other services.

<sup>12</sup> This category of services may include group living, family living, and supervised living among other services.

<sup>13</sup> This service may include long-term vocational supports.

<sup>14</sup> This service may include critical time intervention, case management, and RICCM.

<sup>15</sup> The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.

<sup>16</sup> Peer supports include individual and group services.

<sup>17</sup> This category of services will be covered an interim basis until the Department completes its implementation of the 1115 SUD waiver and updates to the service definitions for SUD services to completely align with the ASAM criteria.

<b>Section V.C.2 Table 1: State-funded BH, I/DD, and TBI Services</b>		
<b>Disability Group</b>	<b>Core Services</b>	<b>Non-Core Services</b>
	12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment)	

<b>Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to State-funded SUD Services</b>		
<b>ASAM Level of Care</b>	<b>ASAM Service Title</b>	<b>State-funded Service Title</b>
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.1	Clinically managed low intensity residential services	SUD halfway house services
3.3	Clinically managed population-specific high-intensity residential programs	Clinically managed population-specific high-intensity residential programs
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
4	Medically managed intensive inpatient services	Inpatient BH services
OTP	Opioid treatment program	Outpatient opioid treatment
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.2-WM	Clinically managed residential withdrawal	Social setting detoxification services

<b>Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to State-funded SUD Services</b>		
<b>ASAM Level of Care</b>	<b>ASAM Service Title</b>	<b>State-funded Service Title</b>
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

- v. Alternative Services
  - a) The Department intends to release its approach for alternative services in forthcoming guidance.
- vi. Cost Sharing
  - a) The BH I/DD Tailored Plan shall not require recipients to pay any copayment for State-funded BH, I/DD, and TBI services consistent with NC Medicaid’s policy for covered BH I/DD and TBI services.
  - b) The BH I/DD Tailored Plan shall also prohibit providers from requiring recipients to pay any copayment for State-funded BH, I/DD, and TBI services.
- vii. Utilization Management
  - a) UM Program Policy
    1. The BH I/DD Tailored Plan shall develop an UM program for State-funded Services to evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of requests for authorization of State-funded Services against established service definitions
    2. The BH I/DD Tailored Plan shall not delegate its UM program to a Subcontractor.
    3. Subject to Department review and approval, the UM program shall contain written policies and procedures, for, at a minimum, the following:
    4. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
    5. Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
    6. Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
    7. Timeframes for decision making related to service authorizations in accordance with timeframes outlined in the Contract;
    8. Protecting recipients from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a service;
    9. Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization of State-funded Services; and
    10. Dissemination of guidelines to all affected providers and, upon request, to recipients.
    11. The BH I/DD Tailored Plan shall document the UM program, including referral and prior authorization processes for State-funded Services, in a written UM Program Policy and submit to the Department for review one hundred fifty (150) Calendar Days after Contract Award.
    12. The BH I/DD Tailored Plan shall revise the UM Program Policy based on changes requested by the Department. The BH I/DD Tailored Plan shall submit to the Department any

changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.

13. The BH I/DD Tailored Plan shall post the UM Program Policy on its publicly available website for providers and recipients, or in other forms as requested by the provider or recipient, at no cost. The BH I/DD Tailored Plan shall include a prominent reference to the web address of the UM Program Policy in both its provider and Recipient Handbooks.
  14. The BH I/DD Tailored Plan shall conduct training and education with providers on changes to the UM program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.C.4.c. Provider Relations and Engagement*.
  15. The BH I/DD Tailored Plan shall make the CMO or designee available to discuss and report on the UM program, as requested by the Department.
- b) Person-Centered Planning
1. The BH I/DD Tailored Plan shall review and accept or reject Person-Centered Plans submitted with authorization requests for recipients receiving State-funded Services that require Person-Centered Plans (including all recipients transitioning out of State hospitals and adult care homes), and shall require contracted providers to comply with the requirements established in the Department's Records Management and Documentation Manual.
  2. Approval or denial of service or treatment authorization requests associated with a complete Person-Centered Plan satisfies this requirement.
- c) Prior Authorization
1. The BH I/DD Tailored Plan shall use a standardized prior authorization request form developed by the Department.
- d) Service Authorization and Noticing Requirements
1. The BH I/DD Tailored Plan shall provide written notice, using the Department developed template, to recipients on decisions related to authorization of State-funded Services in accordance with 10A NCAC 27G .7004. The written notice shall include the following:
    - a) The basis for such decisions; and
    - b) Sufficient details that inform recipients of the decision, which will provide them with information necessary to determine if they wish to appeal.
  2. For standard authorization decisions, the BH I/DD Tailored Plan shall provide notice as expeditiously as the recipient's condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services.
  3. The BH I/DD Tailored Plan may receive a possible extension of up to fourteen (14) Calendar Days if the recipient requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the recipient's interest.
  4. If the BH I/DD Tailored Plan extends the timeframe beyond fourteen (14) Calendar Days, the BH I/DD Tailored Plan shall provide the recipient and provider with a written notice of the reason for the decision to extend the timeline and inform the recipient of the right to file an appeal if he or she disagrees with that decision.
  5. For expedited authorization decisions, the BH I/DD Tailored Plan shall provide notice no later than seventy-two (72) hours after receipt of the request for service.
  6. The BH I/DD Tailored Plan may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the recipient requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the recipient's interest.
  7. If the BH I/DD Tailored Plan extends the timeframe beyond seventy-two (72) hours, the BH I/DD Tailored Plan shall provide the recipient and provider with a written notice of the

reason for the decision to extend the timeline and inform the recipient of the right to file an appeal if he or she disagrees with that decision.

8. The BH I/DD Tailored Plan shall require providers to use the following BH or other Department approved level-of-care determination and screening tools at part of the BH I/DD Tailored Plan's UM program. The Department reserves the right to change these required screening tools. If this occurs, the Department will notify the BH I/DD Tailored Plan in writing:

- i. Substance use: American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through twelve (12).

- ii. Mental health:<sup>18</sup>

- a) Level of Care Utilization System (LOCUS) scores for adults ages eighteen (18) and older.

- b) Child and Adolescent Level of Care Utilization System (CALOCUS) scores for children and adolescents ages six (6) through seventeen (17).

- c) Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.

- viii. State Operated Health Care Facilities

- a) The BH I/DD Tailored Plan shall comply with the authorization, admission and discharge requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and *Section VII. Attachment N. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the BH I/DD Tailored Plan shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with IDD, TBI or dementia.

- b) Prior to referral or authorization of any potential recipient known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the BH I/DD Tailored Plan must verify that the referral is in accordance with the requirements of N.C. Gen. Stat. § 122C-261 and any other applicable North Carolina law governing the admission of individuals with intellectual disabilities to a State psychiatric hospital.

- c) For recipients who have multiple disorders and medical fragility or have multiple disorders and deafness, the BH I/DD Tailored Plan shall be designated by the Department to determine whether such recipients have such a high level of disability that alternative care is inappropriate, consistent with N.C. Gen. Stat. § 122C-261(e)(4).

- d) In determining whether such recipients are eligible for referral and/or authorization for admission to a State psychiatric hospital, the BH I/DD Tailored Plan must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.

### 3. Care Management and Prevention

#### a. Model Overview and Objectives

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<sup>18</sup> The Department is actively exploring using other assessment tools for mental health services.

- i. The Department believes that recipients of State-funded Services with the highest needs will benefit from care management to avoid unnecessary emergency department visits, hospitalizations and readmissions, and promote linkages to Medicaid and other resources.
  - ii. Under BH I/DD Tailored Plans, the Department intends to implement a two-part approach to provide care and case management to a subset of recipients with the highest needs depending on whether the recipient has a behavioral health condition or I/DD and TBI diagnosis as detailed below.
- b. Case Management for Recipients with Behavioral Health Conditions
- i. For recipients with behavioral health diagnoses, the Department intends to add new case management service definitions for child and adult recipients with mental health and/or SUD needs to its State-funded service array as detailed in *Section V.C.2. Services*. The child service definition will focus on High-Fidelity Wraparound, while the adult service definition will focus on other interventions. The Department intends to release these service definitions at least six months prior to BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan must offer these services beginning at BH I/DD Tailored Plan launch.
  - ii. The BH I/DD Tailored Plan shall hire a State-funded BH Care Management Coordinator to develop policies, practices, and systems that support the provision of case management services as detailed in *Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services*.
    - a) The State-funded BH Care Management Coordinator shall be responsible for the following activities:
      1. Assessing the case management provider network and working with the network management staff to identify gaps in the case management provider network based upon the Network Access Plan as detailed in *Section V.C.4.a.xi.* and waiting list information as detailed in *Section V.C.1.a.xiii.*
      2. Monitoring the delivery of case management services, including reviewing service authorizations for case management services to ensure fidelity of the services delivered, service plans, comprehensive clinical assessments, and person-centered plans.
      3. Ensuring that potential referral sources (e.g., hospitals, community providers, law enforcement agencies, DSS) are aware of case management providers in their area.
      4. Providing support to case management providers to develop a toolkit of medical, behavioral, social and other programs, services, and supports for recipient linkages, leveraging NCCARE360 and 211.org for social services.
      5. Assisting case management providers with identifying and coordinating appropriate placement for recipients with complex needs that are creating barriers to securing an appropriate disposition, including but not limited to recipients who:
        6. Are placed at an inappropriate level of care or are at risk of being discharged from their current placement due to their complex needs;
        7. Have a medical co-morbidity (including pregnancy);
        8. Have co-occurring mental health, SUD, I/DD, and/or TBI disorders;
        9. Have complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions; or
        10. Have a legal history affecting ability to live in congregate settings and/or in proximity to children.
  - iii. Qualifications for the State-Funded BH Care Management Coordinator
    - a) The BH I/DD Tailored Plan shall ensure that State-funded BH Care Management Coordinator(s) have the following minimum qualifications:
      1. Be a Master's-level fully Licensed Clinical Social Worker (LCSW), Licensed (Licensed Clinical Mental Health Counselor (LCMC), or Licensed Psychological Associate (LPA); and

2. Three (3) years of supervisory experience of staff working directly with individuals with a BH condition who have complex needs.
- iv. The BH I/DD Tailored Plan shall ensure recipients with complex needs as described in *Section V.C.3.b.ii.a)* 5. are placed in a timely manner in appropriate settings
- c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations
  - i. The BH I/DD Tailored Plan shall provide care management to a subset of uninsured high needs recipients with I/DD or TBI diagnoses.
  - ii. Children and adults with I/DD and TBI diagnoses, as defined by N.C. Gen. Stat. §§ 122C-3(12A) and 122C-3(38a) respectively, shall be eligible for care management delivered through the BH I/DD Tailored Plan if they are found ineligible for Medicaid and meet all of the following criteria:
    - a) Are not connected to or are disengaged from community-based services that are available to meet their clinical needs;
    - b) Require coordination between two or more agencies, including medical or non-medical providers and there are no natural or community supports that can provide this coordination;
    - c) Are expected to have difficulty engaging in treatment services without additional support;
    - d) They are ineligible for provider-based case management services; and
    - e) They meet one of the following criteria:
      1. Reside in or are at risk of entry into institutional settings (e.g., state developmental facilities, ICF-IIDs, state psychiatric facilities or adult care homes);
      2. Are justice-involved;
      3. Have behavioral complexity resulting in recurrent crisis service usage (e.g., emergency department, BH urgent care and facility crisis); or
      4. Are at risk for out of home placement from legal guardians.
  - iii. The BH I/DD Tailored Plan shall be responsible for ensuring that a recipient does not receive duplicative care or case management from multiple sources.
  - iv. The BH I/DD Tailored Plan shall develop a standard methodology and processes for verifying eligibility and prioritizing eligible potential recipients with I/DD or TBI diagnoses for care management.
    - a) The BH I/DD Tailored Plan shall store the results of all reviews of eligibility for care management in a system of record and transmitted monthly in an electronic format to be determined by the Department.
    - b) The BH I/DD Tailored Plan shall share the methodology including the data systems it will use to verify eligibility criteria for care management services with the Department at least annually or as requested by the Department. The BH I/DD Tailored Plan shall verify an individual's eligibility for care management services against its own claims data or against State data resources to which it has access (e.g., NCTracks).
      1. For individuals identified as potentially eligible for Medicaid, the BH I/DD Tailored Plan shall refer them to the county DSS office for assistance.
      2. For those individuals determined eligible for state-funded care management services, the BH I/DD Tailored Plan shall score and prioritize recipients based on need for care management.
      3. The Department shall not specify scoring or prioritization criteria at this time beyond the criteria specified in *Section V.C.3.c.vi.b)*, though the Department expects such criteria are consistently applied to engage individuals in care management given available funding.
  - v. The BH I/DD Tailored Plan shall develop and maintain a waiting list for potential recipients with I/DD or TBI diagnoses who are waiting to receive care management consistent with the requirements in *Section V.C.1.a.xiii*.
    - a) The BH I/DD Tailored Plan shall report the waiting list to the Department on a weekly basis.
  - vi. Referrals for care management delivered by the BH I/DD Tailored Plan

- a) The BH I/DD Tailored Plan shall accept referrals for potential recipients who could benefit from care management from all sources, including, but not limited to:
  - 1. BH I/DD Tailored Plan staff;
  - 2. Providers (e.g., hospital, facility or community-based providers);
  - 3. State agencies;
  - 4. Community based organizations;
  - 5. Law enforcement; and
  - 6. Self/guardian/legal representative.
- b) The BH I/DD Tailored Plan shall prioritize referrals for potential recipients who have an immediate risk in the next three (3) months for one of the criteria specified in *Section V.C.3.c.vi*.
- vii. Care management comprehensive assessment for care management for recipients with I/DD or TBI diagnoses delivered by the BH I/DD Tailored Plan
  - a) The BH I/DD Tailored Plan shall develop a standardized person-centered Care Management Comprehensive Assessment of a qualifying recipient’s healthcare needs, functional needs, accessibility needs, strengths and supports, goals, and other characteristics that will inform the recipient’s ongoing Individual Support Plan (ISP) and treatment.
  - b) The BH I/DD Tailored Plan shall develop methodologies and tools for conducting the Care Management Comprehensive Assessment, as appropriate for differing recipient demographics and needs.
  - c) The Care Management Comprehensive Assessment shall include, at a minimum, the following domains:
    - 1. Recipient’s immediate care needs;
    - 2. Recipient’s current services and providers;
    - 3. Functional needs, accessibility needs, strengths and goals;
    - 4. Other state or local services currently used;
    - 5. Physical health conditions, including dental conditions;
    - 6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
    - 7. Physical disabilities;
    - 8. I/DD;
    - 9. Detailed medication history a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies
    - 10. Available informal, caregiver or social supports;
    - 11. Standardized Unmet Health-Related Resource Need questions to be provided by the Department, covering the Department’s four (4) priority domains: housing, food, transportation and interpersonal safety;
    - 12. Any other ongoing conditions that require a course of treatment or regular care monitoring;
    - 13. Exposure to trauma;
    - 14. Risks to the health, well-being, and safety of the recipient and others (including sexual activity, potential abuse/exploitation and exposure to secondhand smoke and aerosols);
    - 15. Cultural considerations (e.g., ethnicity, religion, language, reading level, health literacy, etc.);
    - 16. Employment/community involvement;
    - 17. Education (including individualized education plan and lifelong learning activities)
    - 18. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
    - 19. Self-management and planning skills; and

20. Receipt of and eligibility for entitlement benefits.
- d) The BH I/DD Tailored Plan shall make its best effort to complete the Care Management Comprehensive Assessment for every eligible recipient of State-funded care management subject to available funding, as described in *Section V.C.3.*, who has been referred to the BH I/DD Tailored Plan for care management within fourteen (14) Calendar Days of referral.
  - e) The BH I/DD Tailored Plan shall ensure that the Care Management Comprehensive Assessment is conducted in a location that meets the recipient's needs.
  - f) The BH I/DD Tailored Plan shall ensure that care managers make a best-effort attempt to complete the assessment in-person, realizing that in limited instances it will be necessary to complete the assessment via HIPAA compliant technology conferencing tools (e.g., audio, video and/or web).
  - g) The BH I/DD Tailored Plan shall ensure the results of the Care Management Comprehensive Assessment are shared with the recipient's behavioral health, I/DD, and TBI providers within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, with the recipient's consent to the extent required by law. The BH I/DD Tailored Plan shall not withhold necessary State-funded BH, I/DD or TBI services for recipients while awaiting completion of the Care Management Comprehensive Assessment.
- viii. Development of the ISP for Recipients with I/DD or TBI Diagnoses
- a) The BH I/DD Tailored Plan shall develop a standardized template for ISPs for recipients of State-funded care management with an I/DD or TBI. The BH I/DD Tailored Plan shall submit the ISP template to the Department for approval as part of the State-Funded Care Management Policy for Recipients with I/DD and TBI described in *Section V.C.3.c.xiv.* Required elements of the ISP are described in more detail below.
  - b) The BH I/DD Tailored Plan shall ensure that the ISP is developed and presented in a manner understandable to the recipient, including consideration for the recipient's reading level and alternate formats.
  - c) The BH I/DD Tailored Plan shall ensure that each ISP incorporates results of the Care Management Comprehensive Assessment, claims analysis, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
    - 1. NC SNAP
    - 2. SIS®, as available
  - d) Each ISP shall contain, at a minimum:
    - 1. Measurable goals;
    - 2. Clinical needs including any I/DD-related, TBI-related, behavioral health-related, or dental needs;
    - 3. Interventions including addressing medication management, including access and adherence;
    - 4. Intended outcomes;
    - 5. Social, educational, and other services needed by the recipient;
    - 6. Strategies to increase social interaction, employment, and community integration;
    - 7. Emergency/natural disaster/crisis plan;
    - 8. Strategies to mitigate risks to the health, well-being, and safety of recipients and of others;
    - 9. Information about Advance Directives, including psychiatric advance instructions, as appropriate; and
    - 10. Strategies to improve self-management and planning skills.
  - e) For eligible recipients for whom the BH I/DD Tailored Plan has completed a Care Management Comprehensive Assessment, the BH I/DD Tailored Plan shall use the results of the Care

Management Comprehensive Assessment to develop an ISP for recipients with I/DD and TBI needs.

- f) The BH I/DD Tailored Plan shall be responsible for ensuring that the ISP is complete and reviewing it for quality control.
- g) The BH I/DD Tailored Plan shall ensure that each ISP is individualized and person-centered and is developed using a collaborative approach including recipient and family participation where appropriate.
- h) The BH I/DD Tailored Plan shall make best efforts to complete an ISP within thirty (30) Calendar Days of the completion of the Care Management Comprehensive Assessment.
  - 1. "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the recipient's home or working with a known provider to meet the recipient at an appointment, to contact the recipient if the first attempt is unsuccessful
- i) The BH I/DD Tailored Plan shall ensure that development of the ISP does not delay the provision of needed State-funded BH, I/DD or TBI services to a recipient in a timely manner, even if that recipient is waiting for an ISP to be developed.
- j) The BH I/DD Tailored Plan shall ensure that each ISP is documented and stored and made available to the recipient and the following representatives within fourteen (14) Calendar Days of completion of the ISP:
  - 1. Other providers authorized to deliver care to the recipient;
  - 2. The recipient's legal representative (as appropriate);
  - 3. The recipient's caregiver (as appropriate, with consent);
  - 4. Social service providers (as appropriate, with consent); and
  - 5. Other individuals identified and authorized by the recipient.
- ix. Care management functions for recipients with I/DD or TBI diagnoses delivered by the BH I/DD Tailored Plan
  - a) The BH I/DD Tailored Plan shall ensure that each recipient who is actively engaged in care management provided by the BH I/DD Tailored Plan receives care management according to their ISP.
  - b) The BH I/DD Tailored Plan shall ensure that care management includes:
    - 1. Conducting health and social needs assessments and developing ISPs;
    - 2. Coordinating and providing referral, information and assistance in obtaining and maintaining State-funded Services;
    - 3. Coordinating social services and services geared toward a recipient's unmet health-related resource needs;
    - 4. Providing referral, information, and assistance in obtaining and maintaining low or no cost medical services (e.g., from federally qualified health centers (FQHCs) and rural health centers (RHCs), community-based resources and social support services);
    - 5. Conducting continuous monitoring of progress toward goals identified in the ISP through contacts with the recipient;
    - 6. Following up on referrals;
    - 7. Conducting transitional care management (as described below); and
    - 8. Working with recipients' providers to help coordinate resources during a crisis event, as determined feasible and appropriate.
  - c) The BH I/DD Tailored Plan shall ensure that care management addresses unmet health-related resource needs, including the following activities at a minimum:
    - 1. Provide referral, information and assistance in obtaining and maintaining community-based resources and social support services, including:
    - 2. Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers)

3. Food and nutrition supports (e.g., SNAP, WIC)
  4. Housing
  5. Transportation
  6. Employment services
  7. Education
  8. Child welfare services
  9. Domestic violence services
  10. Legal services
  11. Services for justice-involved populations
  12. Other services that help individuals achieve their highest level of function and independence
  13. Provide assistance securing Medicaid enrollment for recipients who may be eligible, including assistance at initial application with filling out and submitting applications, and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach.
  14. Connect recipients to programs and resources that can assist in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.
- d) The BH I/DD Tailored Plan shall have a single care management data system across Medicaid and State-funded Services.
  - e) The BH I/DD Tailored Plan shall maintain a Medicaid and State-funded Services care management data system capable of the following functions, recognizing that certain functions will not be relevant to SFS;
    1. Ingesting and using available BH, I/DD and TBI claims, and encounter data (including those captured by “shadow claims”), clinical data, risk stratification information and/or unmet health-related needs data;
    2. Maintaining up-to-date documentation of recipients obtaining care management and assignments of individual recipients to care managers;
    3. Electronically documenting and storing the Care Management Comprehensive Assessment;
    4. Electronically documenting and storing the ISP;
    5. Identifying risk factors for individual recipients;
    6. Monitoring and quickly responding to changes in a recipient’s health status;
    7. Tracking a recipient’s referrals;
    8. Developing reports and summaries of care records for other care providers (as necessary); and
    9. Supporting data analytics and performance measurement, and sending quality measures (where applicable).
  - x. Transitional care management for recipients with I/DD or TBI diagnoses obtaining care management delivered by the BH I/DD Tailored Plan
    - a) The BH I/DD Tailored Plan shall oversee care transitions for recipients obtaining care management through the BH I/DD Tailored Plan who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.
    - b) The BH I/DD Tailored Plan shall develop a process for identifying recipients already obtaining care management in transition who are at risk of readmissions and other poor outcomes. This process shall take into account discharges from inpatient, residential, or facility-based services

including behavioral health urgent care, facility-based crisis services, clinically managed population-specific high-intensity residential program, ICF-IID, or NC START.

- c) The BH I/DD Tailored Plan must ensure that its contracts with institutions in the BH I/DD Tailored Plan provider network (hospitals, residential settings, rehabilitation settings, State Operated Health Care Facilities, and other treatment settings) establish policies and procedures for transitional care management that require the institution to:
  - 1. Permit the care manager to engage in and help coordinate the discharge planning process;
  - 2. To the maximum extent feasible, notify the BH I/DD Tailored Plan of recipient admissions/pending discharges to integrate the BH I/DD Tailored Plan into the discharge/transition planning process; and
  - 3. Share relevant information (including the recipient's current ISP, initial and final discharge plans, and medical information) among transition/discharge planning team recipients and the recipient's care manager.
- d) As part of transitional care management, the BH I/DD Tailored Plan shall ensure that there is a clinically appropriate process for following up with a recipient undergoing transitions, including:
  - 1. Same-day or next-day outreach; and
  - 2. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits).
- xi. Location of Care Management for Recipients with I/DD or TBI Diagnoses
  - a) The BH I/DD Tailored Plan shall provide care management services in-person, at provider- or community-based settings, to recipients to the maximum extent possible.
  - b) The BH I/DD Tailored Plan shall ensure that the care manager provides a minimum of one (1) visit to the recipient's home, office setting, homeless shelter, libraries, streets or other community settings to assess a recipient's current functioning and level of need.
  - c) The BH I/DD Tailored Plan shall ensure that the care manager contacts the recipient on a weekly basis to ensure the recommended support has been provided.
  - d) The BH I/DD Tailored Plan shall ensure that care managers thoroughly document care management services delivered, including noting phone numbers, meeting locations, conversation lengths, and dates.
- xii. Duration of Care Management for Recipients with I/DD or TBI Diagnoses
  - a) Care management delivered by the BH I/DD Tailored Plan is intended to serve as a short-term engagement service and not as long-term method of service delivery.
  - b) The BH I/DD Tailored Plan shall ensure that the duration of care management not exceed 90 days.
  - c) To the maximum extent possible, the BH I/DD Tailored Plan shall aim to provide care management to eligible recipients until the recipient's need has been addressed to the greatest possible degree, including linkages to care and secured placement, as applicable.
- xiii. Staffing and Training Requirements for Care Managers Serving Recipients with I/DD or TBI Diagnoses
  - a) The BH I/DD Tailored Plan shall employ care manager(s) to provide care management services to eligible State-funded Services recipients with I/DD and TBI.
  - b) The BH I/DD Tailored Plan shall ensure that care managers serving recipients with I/DD and TBI needs meet the following qualifications:
    - 1. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area, and
    - 2. At least two (2) years of experience working directly with individuals with I/DD or TBI.

- c) The BH I/DD Tailored Plan shall ensure that the caseload size for a care manager does not exceed forty (40) recipients.
- d) The BH I/DD Tailored Plan shall ensure that care managers are supervised by supervising care managers. The supervising care managers must have the following minimum qualifications:
  - 1. A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; or
  - 2. A Master's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.
- e) Care Management Training for Care Managers Serving Recipients with I/DD or TBI Diagnoses
  - 1. The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes the domains the following domains at a minimum in addition to any training requirements specified in N.C. General Statute § 122c-115.4:
  - 2. BH I/DD Tailored Plan eligibility and services
    - a) BH I/DD Tailored Plan eligibility criteria;
    - b) Principles of integrated and coordinated physical and BH care and I/DD and TBI services;
    - c) BH crisis response; and
    - d) Knowledge of Innovations and TBI waiver eligibility criteria.
  - 3. Whole-person health and unmet resource needs
    - a) Understanding and addressing ACEs, trauma, and trauma-informed care;
    - b) Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the recipient navigate available social supports and resources at the recipient's local level; and
    - c) Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect recipients.
  - 4. Community integration
    - a) Independent living skills;
    - b) Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities;
    - c) Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community; and
    - d) Available programs and resources to assist recipients in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.
  - 5. Health promotion
    - a) Common physical comorbidities of recipients;
    - b) Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease);
    - c) Common environmental risk factors including but not limited to the health effects of exposure to second and thirdhand tobacco smoke, and e-cigarette aerosols and liquids and their effects on family and children;
    - d) Standard of care for tobacco treatment, including both counseling and FDA approved tobacco treatment medications;

- e) Brief tobacco use intervention and referral to treatment;
  - f) Self-management and self-help recovery resources (including substance use recovery);
  - g) Roles and responsibilities for medication management; and
  - h) Use of IT in Care Management Comprehensive Assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360.
6. Other care management skills
- a) Transitional care management best practices;
  - b) Supporting health behavior change, including motivational interviewing;
  - c) Person-centered needs assessment and care planning, including LTSS needs;
  - d) Preparing recipients for and assisting them during emergencies and natural disasters;
  - e) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training recipients on proper practices, particularly for recipients receiving care in the home or community settings, or as recipients transition across care settings.
  - f) General understanding of virtual (e.g., Telehealth) applications in order to assist recipients in using the tools
  - g) Understanding needs of the justice-involved population; and
  - h) Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment.
7. I/DD or TBI-specific topics
- a) Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers;
  - b) Understanding HCBS, related planning, and 1915(c) services and requirements;
  - c) Accessing and using assistive technologies to support individuals with I/DD and TBI;
  - d) Understanding the changing needs of individuals with I/DD and TBI as they age; and
  - e) Educating recipients with I/DD and TBI about consenting to physical contact and sex.
8. Additional trainings for care managers and supervisors serving recipients with LTSS needs
- a) Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission.
9. The BH I/DD Tailored Plan shall ensure care managers and supervising care managers serving its recipients are trained on all the topics described in *Section V.C.3.c.xii.e*.
10. The BH I/DD Tailored Plan must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.
11. The BH I/DD Tailored Plan shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.
12. The BH I/DD Tailored Plan shall identify core modules that care managers must complete before being deployed to serve recipients; care managers must complete the remaining training modules within thirty (30) days of being deployed to serve recipients.
- xiv. State-Funded Care Management Policy for Recipients with I/DD and TBI
- a) The BH I/DD Tailored Plan shall submit its State-funded Care Management Policy for Recipients with I/DD and TBI for review and approval by the Department within one hundred fifty (150)

Calendar Days after Contract Award. The BH I/DD Tailored Plan must submit an updated version of the State-funded Care Management Policy for Recipients with I/DD and TBI sixty (60) Calendar Days prior to BH I/DD Tailored Plan launch and at the beginning of each contract year.

- b) The State-funded Care Management Policy for Recipients with I/DD and TBI shall include the BH I/DD Tailored Plan's policies and processes for:
1. Methodology for prioritizing potential recipients with I/DD and TBI for care management;
  2. Care Management Comprehensive Assessments, including but not limited to:
    - a) Assessment tools/questions used;
    - b) Expected volume of Care Management Comprehensive Assessment monthly and annually; and
    - c) Method of conducting the Care Management Comprehensive Assessment based on recipient needs or other factors;
  3. ISP development with recipients, including standardized ISP template, approach for ensuring that ISPs are individualized and person-centered and that the recipient and the recipient's family, advocates, caregivers, and/or legal guardians are actively involved;
  4. Proposed locations of care management delivery, including whether the services will be delivered in-person, via two-way real time video and audio conferencing, or telephonically;
  5. Training and qualification of care managers including timing/frequency of training, curricula, how completion of trainings will be tracked, training modalities (e.g., in-person versus online), how competencies will be assessed and ongoing continuing education;
  6. Linkages with community resources for all recipients as needed, including for those identified as having unmet health-related resource needs;
  7. Provision of information and navigation regarding community providers of social services;
  8. Transitional care management;
  9. Diversion; and
  10. Requisite health IT infrastructure technologies and data privacy security policies.
- d. Diversion from Institutional Settings
- i. Diversion Overview
    - a) In addition to the diversion requirements identified in *Section V.B.3.ii.(xii) Diversion from Institutional settings*, the BH I/DD Tailored Plan shall assume primary responsibility for identifying non-Medicaid covered potential recipients who are being considered for admission to an ACH, and performing diversion activities, as described in this Section.
    - b) The BH I/DD Tailored Plan shall provide the diversion reports in the form and frequency as described in *Section VII. Attachment J. Reporting Requirements*.
  - ii. Eligibility for Diversion
    - a) The BH I/DD Tailored Plan shall be responsible for identifying non-Medicaid covered potential recipients eligible for state-funded diversion activities.
      1. Non-Medicaid covered potential recipients shall be eligible for state-funded diversion activities if they meet the TCLI eligibility criteria set forth in the Settlement Agreement and LME-MCO Communication Bulletin #J281 dated March 14, 2018.
      2. The Department retains the right to modify eligibility criteria for state-funded diversion activities.
  - iii. Staffing Requirements
    - a) Diversion activities shall be performed by a BH I/DD Tailored Plan-based Diversion Specialist.
    - b) The BH I/DD Tailored Plan shall ensure that a Diversion Specialist has the following minimum qualifications:
      1. Must be knowledgeable about community services and supports, including supportive housing.

2. Must be a fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or Registered Nurse (RN), in North Carolina; and have one (1) year of relevant supervisory experience working with individuals with SMI unless they meet the following conditions:
  3. Individuals with relevant and direct experience providing diversion services under TCLI may continue to provide diversion services without meeting the minimum qualifications for Diversion Specialists described in this Section.
  4. The BH I/DD Tailored Plan must ensure that a Diversion Specialist who is not an RN can consult with a BH I/DD Tailored Plan-based RN or other BH I/DD Tailored Plan-based medical staff to assess the medical needs of the recipient receiving diversion services.
- c) The BH I/DD Tailored Plan shall conduct training for Diversion Specialists that addresses the following domains:
1. Eligibility for BH I/DD Tailored Plan services, including state-funded services, and low- or no-cost services such as those available through a FQHC.
  2. Whole-person health and unmet resource needs, including LTSS needs and navigating social supports and local resources.
  3. Programs that support community integration, including independent living skills, Permanent Supportive Housing, employment resources and supports, education supports and other types of productive activity.
  4. Transitional care management best practices, including person-centered needs assessment and care planning, and LTSS needs.
  5. Assessing living arrangements for health and safety issues.
  6. For Diversion Specialists working with recipients with LTSS needs:
  7. Methods for coordinating with supported employment resources.
- d) The Department reserves the right to specify the training curriculum that BH I/DD Tailored Plans must use for diversion.
- e) The Department shall establish caseload requirements for BH I/DD Tailored Plan-based Diversion Specialists.
- iv. Diversion Activities
- a) The BH I/DD Tailored Plan shall perform the following diversion activities in a timely manner to ensure diversion is successful:
1. Screen and assess the recipient for eligibility for State-funded Services, Medicaid eligibility, and other entitlement programs beyond Medicaid.
  2. Educate the recipient on the choice to remain in the community and the services that would be available to support that decision.
  3. Coordinate and provide referral, information and assistance in obtaining and maintaining State-funded Services.
  4. Coordinate social services and services geared toward a recipient's unmet health-related resource needs.
  5. Provide referral, information, and assistance in obtaining and maintaining low or no cost medical services (e.g., from FQHCs and RHCs, community resources and social support services).
  6. Determine if the recipient is eligible for supportive housing, if needed.
  7. For those who choose to remain in the community:
  8. Develop a Community Integration Plan (CIP) that clearly documents that the recipient's decision to remain in the community was based on informed choice, and the degree to which the recipient's decision has been implemented.

9. Integrate the recipient's CIP as an addendum in the recipient's Care Plan if the recipient enrolls in Medicaid.
  10. For recipients with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.
  11. Refer all non-Medicaid covered recipients who choose to enter an institutional setting or ACH for in-reach services described in *Section V.C.3.e. In-Reach and Transition from Institutional Settings*.
- b) The BH I/DD Tailored Plan shall ensure all diversion activities are documented and stored and made available to the Department for review upon request.
- e. In-Reach and Transition from Institutional Settings
- i. In-Reach and Transition Overview
    - a) The BH I/DD Tailored Plan shall have primary responsibility for the in-reach and transition activities described in this Section.
      1. In-reach activities shall be conducted with the goal of identifying and engaging non-Medicaid covered potential recipients receiving care in a setting described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services* who may be able to have their needs safely met in a community setting.
      2. Transition activities shall be conducted with the goal of facilitating the relocation of a non-Medicaid covered recipient receiving services in a setting described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services* to a community setting, while ensuring the appropriate level of services and supports that recipient requires.
    - b) The BH I/DD Tailored Plan shall ensure all in-reach and transition activities are documented and stored and made available to the Department for review upon request.
    - c) The BH I/DD Tailored Plan shall provide the in-reach and transition reports in the form and frequency as described in *Section VII. Attachment J. Reporting Requirements*.
  - ii. Eligibility for In-Reach and Transition Services
    - a) All non-Medicaid covered potential recipients with SMI residing in an ACH or state psychiatric hospital who meet the TCLI eligibility criteria set forth in the Settlement Agreement and LME-MCO Communication Bulletin #J281 dated March 14, 2018, subject to the availability of State funds, shall be eligible for state-funded in-reach and transition activities.
      1. The Department retains the right to modify eligibility criteria for state-funded in-reach and transition activities.
  - iii. The BH I/DD Tailored Plan shall verify the in-reach staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements* perform the following in-reach activities, beginning within seven (7) days of admission and occurring on a regular basis until the recipient is referred for transition services described in *Section V.C.3.e.iv. Transition Activities*.
    - a) Identify candidates for in-reach services. The BH I/DD Tailored Plan, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
      1. Facility referrals;
      2. Information provided by the Department;
      3. Stakeholder and family/guardian referrals; and
      4. Automatic in-reach trigger points the BH I/DD Tailored Plan shall establish.
    - b) Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the recipient and the recipient's family members and/or guardians are accurately and fully informed about community-based options available to them, including supportive housing.
    - c) Facilitate and accompany the recipient and the recipient's family members and/or guardians on visits to community-based services.

- d) Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing and Medicaid eligibility.
- e) To the maximum extent possible, explore and address the concerns of the recipient and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for Permanent Supportive Housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns.
- f) For recipients who decline the opportunity to transition or decline Permanent Supportive Housing that would allow them to transition:
  - 1. Continue to engage the recipients and/or their family members or guardians about the opportunity to transition to a more integrated setting and develop and implement individualized strategies to address concerns and objections to placement in an integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
  - 2. Clearly document that the recipient's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the recipient of available community services, including supportive housing.
  - 3. While the recipient remains in an ACH or state psychiatric hospital, continue to monitor the individual and continue to provide in-reach and transition activities.
- g) Provide the recipient and/or their family members or guardians opportunities to meet with other individuals with SMI who are living, working and receiving services in integrated settings.
- h) Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI to live in their home/community.
- i) For recipients who are identified for transition, refer the recipients to a BH/IDD Tailored Plan-based transition coordinator or DSOHF Admission Through Discharge Manager (see *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*) assigned to the recipient by the BH I/DD Tailored Plan and ensure a timely, Warm Handoff from the in-reach staff.
- j) Additional required activities for recipients who may be eligible for supportive housing:
  - 1. Ensure the recipient and the recipient's family members and/or guardians are accurately and fully informed about all available Permanent Supportive Housing options.
  - 2. Facilitate and, if necessary, accompany the recipient and the recipient's family members and/or guardians on visits to Permanent Supportive Housing settings.
- iv. The BH I/DD Tailored Plan shall verify the transition staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements* perform the following transition activities:
  - a) Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care upon referral from the from the BH I/DD Tailored Plan in-reach staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*.
  - b) Collaborate with facility staff to assist the recipient with completing a Medicaid application prior to discharge.
  - c) Collaborate with the following individuals, specialists, and provider types as applicable depending on recipient's needs, participating in all transition meetings to ensure effective and timely discharge and transition to community:
    - 1. The recipient and/or the recipient's family or guardian
    - 2. Facility providers
    - 3. Facility discharge planners
    - 4. Provider who will be delivering state-funded case management to the recipient or care manager, if applicable or care manager performing Tailored Care Management (for individuals transitioning to Medicaid upon release)

5. The recipient's community-based PCP, if applicable
  6. Peer support specialist or other individuals determined to have appropriate shared lived experience
  7. Educational specialists
  8. Other community providers and specialists as appropriate in the transition planning process, including physical health providers, and BH providers.
- d) Work with the recipient's community providers as appropriate so that they are actively engaged in the transition planning process prior to the recipient's discharge.
  - e) Assist the recipient, prior to discharge, either by phone or in-person, to identify qualified community providers and clinical specialists as needed, including assisting the recipient and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
  - f) Collaborate with the recipient and/or their family members or guardians, Peer Support Specialists when available, facility providers, and other relevant community service providers to make arrangements for individualized state-funded or low or no cost community supports and services needed to be in place upon discharge.
  - g) Collaborate with the recipient and/or their family members or guardians, the facility provider, and selected community provider(s) prior to the recipient's discharge to identify and prioritize the most critical services necessary and available to address the recipient's specific needs, including complex BH, primary care and medical needs, which may be met through referrals to free or no cost providers (e.g., FQHC and RHC).
  - h) Schedule post-discharge appointments for critical services based upon the recipient's identified needs, including LTSS, to occur at the earliest time necessary to ensure a successful transition and no later than seven (7) Calendar Days following discharge.
  - i) When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
  - j) Assist the recipient and/or the recipient's family members or guardians in initiating selected community service options.
  - k) Work with receiving providers and/or agency if applicable to identify if any specific training is needed by the receiving providers and/or agency if applicable to ensure a seamless transition.
  - l) Address any identified barriers, to the maximum extent possible, to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), resource identification, referrals to qualified providers and care manager, and training of family or guardians and natural supports prior to the recipient's discharge.
    1. Transition staff shall assess settings that the recipient is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.C.3.e.xii. In-Reach and Transition Policy*.
  - m) When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the recipient's individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.
    1. If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the recipient's discharge.

2. Make best efforts to ensure that the information contained in the discharge service order, the ninety (90)-day transition plan and the discharge summary are made available to the community providers who will be serving the recipient after discharge.
- n) Verify the discharge service order, the transition plan and the discharge summary are made available to the care manager performing Tailored Care Management (for recipients transitioning to Medicaid upon discharge) or the provider offering State-funded case management.
  - o) Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct patient population served, and the discharge and transition responsibilities included in the Department contract including those set forth in this Section.
  - p) Following discharge, ensure the transition coordinator performs the following activities:
    1. Ensure recipient is receiving needed transition-related services.
    2. Coordinate and facilitate thirty (30)-day post-discharge meetings with the recipient and the recipient's family members or guardians, the provider delivering state-funded case management to the recipient, and community provider(s) including NC START (if applicable) to promptly address any areas of concern identified following transition of the recipient from the facility to the community.
    3. Convene follow-up post-discharge meetings every thirty (30) days until any issues or areas of concern are addressed.
  - q) Additional required activities for recipients who may be eligible for supportive housing:
    1. Collaborate with the recipient and/or the recipient's family members or guardians and the BH I/DD Tailored Plan's housing specialist to make arrangements for housing services needed to be in place upon discharge.
    2. Assist the recipient and/or the recipient's family members or guardians in initiating housing-related services and supports, including but not limited to: locating and securing housing; ensuring the home environment is safe and move-in ready; and other ongoing tenancy supports that enable the recipient to maintain their housing.
    3. Ensure transition is completed within ninety (90) days of receiving a housing slot.
  - r) Referral to Care Management
    1. The BH I/DD Tailored Plan shall assign recipients transitioning out of a state psychiatric hospital or ACH to a care manager in Tailored Care Manager model (for recipients transitioning to Medicaid), or to a provider offering the State-funded case management service or other state-funded service with case management functions (e.g. CST, ACTT).
    2. Assignment or referral shall happen upon referral from the transition coordinator or DSOHF Admission Through Discharge Manager prior to discharge if the recipient has not transferred to another service that includes a case management function.
    3. The BH I/DD Tailored Plan shall ensure a Warm Handoff to the recipient's assigned care manager or provider offering the case management service definition.
    4. The Warm Handoff to the recipient's assigned care manager or provider offering the case management service definition shall take place upon discharge.
    5. The transition coordinator or DSOHF Admission Through Discharge Manager shall ensure the care manager or provider offering the case management service meets with the recipient and/or their family members or guardians prior to discharge.
    6. The transition coordinator shall remain a part of the recipient's care team, as applicable, following the Warm Handoff until ninety (90) days post-discharge. During this time the transition coordinator shall remain available to the care manager or provider offering the case management service for consult.

- s) The BH I/DD Tailored Plan shall assign a member of the BH I/DD Tailored Plan clinical leadership (i.e. clinical Director-level or above) to attend and participate in case discussions and transition planning for recipients with complex needs identified by facility clinical leadership, such as recipients with co-occurring disorders or a history of aggression and/or serious self-harm.
- v. Staffing Requirements
  - a) The BH I/DD Tailored Plan may operate its in-reach and transition activities utilizing shared staffing and infrastructure with its Medicaid member in-reach and transition activities.
  - b) As described in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that in-reach activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based peer support specialist.
  - c) As described in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the following parties are responsible for transition activities:
    1. For recipients transitioning from an ACH or state psychiatric hospital to supportive housing, transition activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based transition coordinator.
    2. For all other recipients transitioning from a state psychiatric hospital, transition activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by the DSOHF Admission Through Discharge Manager.

<b>Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements</b>			
	<b>Setting</b>	<b>In-Reach Staff Position</b>	<b>Transition Staff Position</b>
1.	State Psychiatric Hospital	BH I/DD Tailored Plan-Based Peer Support Specialists	<p><i>For recipients transitioning to supportive housing: BH I/DD Tailored Plan-Based Transition Coordinators</i></p> <p><i>For all other recipients: DSOHF Admission Through Discharge Manager</i></p>
2.	ACH	BH I/DD Tailored Plan-Based Peer Support Specialists	BH I/DD Tailored Plan-Based Transition Coordinators

- d) Transition Supervisor Requirements
  1. The BH I/DD Tailored Plan shall ensure that all BH I/DD Tailored Plan-based in-reach and transition staff working with recipients who are in or transitioning out of a state psychiatric hospital or ACH are supervised by a transition supervisor.
  2. The BH I/DD Tailored Plan shall ensure Transition Supervisors have no caseload but will provide coverage for other in-reach and transition staff's vacation and sick leave.
  3. The BH I/DD Tailored Plan shall ensure Transition Supervisors are responsible for providing guidance to Peer Support Specialists, Transition Coordinators, and DSOHF Admission Through Discharge Manager working with recipients transitioning out of a state psychiatric hospital or an ACH.

4. The BH I/DD Tailored Plan shall ensure Transition Supervisors attend and participate in case discussions and transition planning for recipients with complex needs identified by facility clinical leadership, such as recipients with co-occurring disorders or a history of aggression and/or serious self-harm.
  - e) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager per state psychiatric hospital associated with the BH I/DD Tailored Plan's region.
  - f) The BH I/DD Tailored Plan shall ensure all in-reach and transition staff report potential rights violations of recipients residing in ACHs in accordance with General Statute 131D.
- vi. In-Reach and Transition Staff Qualifications
- a) The BH I/DD Tailored Plan shall ensure that Peer Support Specialists serving recipients residing in an ACH or state psychiatric hospital have the following minimum qualifications:
    1. NC Certified Peer Support Specialist Program Certification; and
    2. Specific background and expertise working with people with SMI and their families or guardians, and
    3. Must be knowledgeable about community services and supports, including supportive housing.
  - b) The BH I/DD Tailored Plan shall ensure that DSOHF Admission Through Discharge Managers serving residents of state psychiatric hospitals have the following minimum qualifications:
    1. Master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), or bachelor's-level registered nurse (RN) plus one (1) year of experience working directly with individuals with SMI.
  - c) The BH I/DD Tailored Plan shall ensure that Transition Coordinators meet the following minimum qualifications:
    1. Master's degree in a human services field or licensure as a registered nurse (RN) plus one (1) year of relevant experience working directly with individuals with SMI; or
    2. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with SMI.
  - d) The BH I/DD Tailored Plan shall ensure that Transition Supervisors overseeing BH I/DD Tailored Plan-based in-reach and transition staff meet the minimum qualifications of a supervising care manager as described in *Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services*. Transition Supervisors shall also meet the following minimum qualifications:
    1. Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
  - e) The BH I/DD Tailored Plan may submit to the Department for approval alternate minimum qualifications for in-reach and transition staff as part of the BH I/DD Tailored Plan In-Reach and Transition Policy as described in *Section V.C.3.e.xii. In-Reach and Transition Policy*.
- vii. In-Reach and Transition Staff Training
- a) In addition to the training domains described in *Section V.C.3.c.xiii. Staffing and Training Requirements for Care Managers Serving Recipients with I/DD or TBI Diagnoses*, the BH I/DD Tailored Plan shall develop a separate training module for in-reach and transition staff that addresses the following domains:
    1. Full knowledge of the array of available community services and supports that ensure the health and well-being and safe community living for recipients working with in-reach and transition staff
    2. Engagement methods including assertive engagement and active listening skills.

3. Motivating and working with a recipient's family or guardian and facility staff, including cultural and linguistic needs of a recipient and the recipient's family or guardian.
  4. Developing an interdisciplinary transition plan.
  5. Fair housing laws including tenancy rights, such as reasonable accommodations and housing inspections for health and safety, and components of the Permanent Supportive Housing model during pre-tenancy, tenancy, and post-tenancy phases, including the process for assessing living arrangements for health and safety issues.
- viii. The Department reserves the right to establish caseload requirements for BH I/DD Tailored Plan-based in-reach and transition staff serving recipients in and transitioning out of a state psychiatric hospital or ACH and will release any additional requirements in forthcoming guidance.
  - ix. The BH I/DD Tailored Plan shall permit their in-reach and transition staff to transport recipients and the recipient's family or guardians when needed to fulfill the required in-reach and transition activities described in this Section.
  - x. The BH I/DD Tailored Plan shall be subject to any additional in-reach and transition requirements issued by the Department, including those developed as part of North Carolina's updated Olmstead Plan.
  - xi. The BH I/DD Tailored Plan shall ensure that one recipient does not receive in-reach and transition services that are duplicative of other care or case management services.
  - xii. In-Reach and Transition Policy
    - a) The BH I/DD Tailored Plan shall submit an In-Reach and Transition Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award and annually thereafter.
    - b) The scope of this policy includes all BH I/DD Tailored Plan recipients eligible for state-funded in-reach and transition services as described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services*.
    - c) The In-Reach and Transition Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing in-reach and transition requirements described in *Section V.B.3.e. In-Reach and Transition from Institutional Settings*, including:
      1. Policies and procedures for outreach and engagement of recipients eligible to receive state-funded in-reach and/or transition services.
      2. Training plan for in-reach and transition staff.
      3. Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support recipient transitions to more integrated settings.
    - d) The In-Reach and Transition Policy shall include a checklist that transition staff will use to assess the safety and appropriateness of settings that BH I/DD Tailored Plan recipients will transition to when leaving a state psychiatric hospital or ACH. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards and are consistent across BH I/DD Tailored Plans.
- f. System of Care
    - i. System of Care Background
      - a) The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina's System of Care is to provide evidence-based, trauma-informed/resiliency developed BH services to all children, youth and their families.
      - b) The BH I/DD Tailored Plan shall use a System of Care approach, including use of specific strategies and protocols described in the BH I/DD Tailored Plan System of Care Policy (*Section V.C.3.f.iii. System of Care Policy*) for all children and youth recipients ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving behavioral health or

substance abuse services, including special populations with a dual I/DD and mental health disorder at risk of out-of-home placement or unable to return from out-of-home placement; youth with dual physical and mental health or SUD diagnoses with or without the risk of out-of-home placement; youth and young adults transitioning from child service systems into adult service systems; and youth involved in the child welfare and/or the juvenile justice system.

- c) The System of Care's core elements are:
  - 1. Family-driven, youth-guided services;
  - 2. Interagency collaboration;
  - 3. Service coordination through a single facilitator;
  - 4. Individualized, strength-based, trauma-informed, resilience-oriented approach;
  - 5. Culturally and Linguistically Competent care;
  - 6. Evidence-based or informed services provided in a home or community setting; and
  - 7. Family and youth involvement in regional and state policy development, implementation, and evaluation.
- ii. System of Care Staffing Requirements
  - a) The BH I/DD Tailored Plan shall employ or contract with the following dedicated System of Care staff:
    - 1. At least one (1) System of Care Coordinator per three (3) counties for the Region in which it operates; and
    - 2. At least one (1) Family Partner per three (3) counties for the Region in which it operates.
  - b) BH I/DD Tailored Plan System of Care Coordinators and Family Partners shall be responsible for comprehensive System of Care planning, implementation, coordination, and training related to required core functions within the Region in which it operates. System of Care Coordinators and Family Partners shall develop, facilitate, and evaluate the following required System of Care functions and responsibilities throughout the Region in which the BH I/DD Tailored Plan operates:
    - 1. Serve as staff to each county local Community Collaborative in the Region in which the BH I/DD Tailored Plan operates and shall recruit and maintain membership that includes family recipients and youth who are receiving or have received public BH services, child-serving agencies and a variety of community partners.
    - 2. Work with Community Collaboratives to:
    - 3. Influence the development of a broad and appropriate service array to meet the range of BH needs of children being serviced under the System of Care framework.
    - 4. Develop the capacity of the Community Collaborative to gather and use data for System of Care decision making.
    - 5. Support BH workforce development through systems partners jointly developing training plans and sharing resources to implement those plans.
    - 6. Develop and implement a strategic communication plan that promotes access to and utilization of BH services, deepens local leadership's understanding of the System of Care framework, and builds public support for local Systems of Care.
    - 7. Foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, work with care managers to ensure that youth and families are leading their person-centered planning processes, and provide and support leadership opportunities for youth and families.
    - 8. Work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of System of Care principles and processes, and provide or facilitate regular consultation, technical assistance and training to provider agencies in System of Care implementation fidelity.

9. Work with community agencies in identifying and responding to community needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and SUD treatment and recovery services.
  10. Regularly identify and respond to consultation, technical assistance and training needs of the Community Collaboratives, provider agencies, families and BH I/DD Tailored Plan staff, and either directly provide such System of Care consultation, technical assistance, and training or facilitate the provision of such activities.
  11. Take an active role in promoting BH I/DD Tailored Plan and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.
  12. Complete and submit BH I/DD Tailored Plan System of Care Reports to the Department. These reports shall be submitted to the Department in accordance with the Department's requirements.
  13. Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits in order to support a high level of statewide coordination, networking, monitoring, and evaluation for and with System of Care Coordinators and staff.
- c) The BH I/DD Tailored Plan shall ensure System of Care Coordinators and Family Partners are trained on all the topics described in this Section.
  - d) The BH I/DD Tailored Plan shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:
    1. Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system;
    2. Partnering with families and youth in Care Plan development, implementation, and evaluation process;
    3. Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive and implementation is shared across sectors;
    4. Developing, supporting and expanding relationships among systems;
    5. Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and
    6. Child and family team care management and HFW.
- iii. System of Care Policy
    - a) The BH I/DD Tailored Plan shall submit a System of Care Policy for review and approval by the Department within one hundred fifty (150) Calendar Days after Contract Award and annually thereafter.
    - b) The scope of this policy includes pediatric and adolescent recipients ages three (3) up to eighteen (18) with a mental health disorder and/or SUD disorders who are receiving behavioral health or substance abuse services, including recipients with a dual I/DD and mental health diagnosis.
    - c) The System of Care Policy shall include a brief description of the BH I/DD Tailored Plan's history and experience coordinating recipients' care under the System of Care framework, including examples of specific successes and challenges to date in meeting the needs of children with BH needs.

- d) The System of Care Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing the System of Care as required in the *Section V.C.3.f.ii. System of Care Staffing Requirements*:
1. Integrating into the System of Care framework and applying the System of Care core elements into its approach for covering services for child and youth recipients with BH needs and their families.
  2. Ensuring that the BH I/DD Tailored Plan is an active partner within a recipient's System of Care.
  3. Supporting coordinated multi-system care delivery through:
  4. Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
  5. Conducting outreach to families with lived experience to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;
  6. Instituting effective and timely cross-system communication, including for children in crisis; and
  7. Collaborating with system partners to ensure that children receive needed services in the least restrictive setting.
  8. Describing how the BH I/DD Tailored Plan will work with local and State public agency partners to:
    - a) Reduce the number and length of out-of-home placements for children receiving public BH services;
    - b) Ensure timely access to an appropriate service array of evidenced-based home- and community-based care for children receiving State-funded BH services;
    - c) Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography.
  9. Describing how the BH I/DD Tailored Plan will develop capacity to strengthen existing and build new relationships with local and State public agency partners youth and/or family members with lived experience with a child in the BH system and local child and family support education and/or advocacy groups, including but not limited to:
    - a) Local school systems;
    - b) County government;
    - c) Juvenile justice system;
    - d) Child welfare system;
    - e) Public health system;
    - f) Private and local community-based providers;
    - g) Child and Family Advisory Committees;
    - h) Community Collaboratives; and
    - i) The DMH/DD/SAS System of Care Coordinator.
- g. Prevention and Population Health Management Programs
- i. The BH I/DD Tailored Plan shall engage in public awareness campaigns, including federally and state-supported campaigns designed to reduce the stigma associated with BH, I/DD and TBI needs and promote prevention, wellness, healthy behaviors and wellness.
  - ii. The BH I/DD Tailored Plan shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by recipients and to improve the emotional health and well-being of their recipients.

- h. Relocation of Recipients Following Emergency Residential Care Facility Closures
  - i. The Department understands that the safe and prompt relocation of recipients residing in licensed residential care facilities that suddenly close requires coordination across multiple Divisions, local services agencies and BH I/DD Tailored Plans.
  - ii. The BH I/DD Tailored Plan shall assist, and in some cases lead, the transition of care and relocation of recipients in licensed residential care facilities subject to Emergency Closure in accordance with the Department’s Operational Guide for a Coordinated Response to a Sudden Closure of an Adult Residential Care Facility or as otherwise defined by the Department, and additional guidance provided by the Department.<sup>19</sup>
  - iii. Emergency Closures of Adult Care Homes:
    - a) The Department has developed an intra-Departmental Emergency Closure “Adult Care Home (ACH) Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions – DHSR, DAAS, and DMH/DD/SAS – BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program (housed within the Area Authorities on Aging).
    - b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closure “ACH Response Hub” upon notification of an Emergency Closure of a licensed group home where members reside.
    - c) The BH I/DD Tailored Plan shall be responsible for relocating recipients following Emergency Closures of ACHs and coordinating with the local DSS on the following activities:
      1. Conduct a site visit of the ACH that is closing;
      2. Identify recipients who are residents;
      3. Meet with recipients and/or guardians;
      4. Implement relocation plan for recipients;
      5. Link recipients to services as appropriate;
      6. Review recipient medication needs and manage personal items;
      7. Participate in daily morning situation calls;
      8. Submit discharge information to local DSS contact person;
      9. Follow up with relocated recipients; and
      10. Participate in debrief conference call after the closure.
  - iv. Emergency Closures of Group Homes
    - a) The Department has developed an intra-Departmental Emergency Closure “Group Home Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents and is comprised of the following Divisional partners: DHSR, DMH/DD/SAS, DHB and DAAS.
    - b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closure “Group Home Response Hub” upon notification of an Emergency Closure of a licensed group home where members reside.
    - c) The BH I/DD Tailored Plan shall be responsible for relocating recipients following Emergency Closures of group homes including:
      1. Conduct a site visit of group home that is closing;
      2. Identify recipients who are residents;
      3. Meet with recipients and/or guardians;
      4. Implement relocation plan for recipients;
      5. Link recipients to services as appropriate;

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<sup>19</sup> The Department’s Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Care Facility is available here: [https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf\\_operational\\_guide.pdf](https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf).

6. Review recipient medication needs and manage personal items;
7. Participate in daily morning situation calls;
8. Submit discharge information to the Department;
9. Follow up with relocated recipients; and
10. Participate in debrief conference call after the closure.

#### 4. Providers

##### a. Provider Network

- i. Providers are the backbone of North Carolina's State-funded Services, and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks BH I/DD Tailored Plans that share and support this tradition.
- ii. The Department seeks a BH I/DD Tailored Plan with a robust State-funded Network to meet the BH, I/DD, and TBI needs of recipients within its Region, including those with limited English proficiency, physical disability or BH I/DD needs. The BH I/DD Tailored Plan shall demonstrate that its State-funded Network will meet Department's availability, access, fidelity and quality goals and requirements as well as that it is willing to act to continuously improve its delivery of health care services to recipients.
- iii. Availability of Services
  - a) The BH I/DD Tailored Plan shall establish and maintain a State-funded Network that is sufficient to ensure that all services are covered under the Contract as detailed in *Section V.C.2.a. State-funded Behavioral Health, I/DD and TBI Services*. State-funded BH, I/DD, and TBI services are available and accessible to recipients in a timely manner as funds are available, as determined by the Department, including those recipients with limited English proficiency or physical or BH I/DD needs, including those on medication assisted treatment (MAT). The BH I/DD Tailored Plan shall enter into a written contract with each Network provider, the terms of which are further specified herein.
  - b) The BH I/DD Tailored Plan shall ensure that no incentive is given to Providers, monetary or otherwise, for withholding medically necessary services.
- iv. Crisis Services
  - a) Consistent with N.C. Gen. Stat. § 122C-117(a)(14), the BH I/DD Tailored Plan shall provide a comprehensive crisis services system that includes a twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year crisis response service and access to a full array of crisis services.
  - b) To promote effective linkages between I/DD crisis service providers, and mobile crisis providers, the BH I/DD Tailored Plan will include within all mobile crisis provider contracts a requirement that a formal, written affiliation agreement be established and maintained with the I/DD crisis service providers in their Region. The agreements will be developed collaboratively between the mobile crisis teams and I/DD crisis services providers and will outline the roles and responsibilities of both parties.
- v. Outpatient Commitment
  - a) The BH I/DD Tailored Plan shall ensure the availability of qualified providers of services provided under Outpatient Commitment to recipients who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment.
  - b) Consistent with the requirements in N.C. Gen. Stat. § 122C-263, the BH I/DD Tailored Plan shall be able to accept a copy of the Outpatient Commitment order for members who are served by Network outpatient treatment physicians and centers.

- c) The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
  - d) Once the BH I/DD Tailored Plan is notified of a recipient's Outpatient Commitment order, the BH I/DD Tailored Plan shall refer the recipient to case management services for its recipients who are under an Outpatient Commitment order in accordance with *Section V.C.3. Care Management and Prevention*.
- vi. Cross Area Service Programs
- a) Any BH I/DD Tailored Plan that wishes to receive State or non-Medicaid federal funding for a Cross Area Service Program (CASP) to provide comprehensive regional or statewide services to individuals residing in multiple BH I/DD Tailored Plan Regions, shall collaborate with the Department to identify and obtain approval in order to designate a provider to receive such designated CASP funds to serve the needs of an identified population.
  - b) The BH I/DD Tailored Plan shall contract with all CASPs located throughout the state that will be listed in forthcoming Department guidance. The BH I/DD Tailored Plan shall use a standard contract for all providers who are CASP according to forthcoming Department guidance.
  - c) The BH I/DD Tailored Plan shall not approve or terminate a CASP contract without Department approval.
  - d) The BH I/DD Tailored Plan shall identify, use and track CASP funding and services as approved by the State General Assembly and designated in Department allocation letters.
  - e) The BH I/DD Tailored Plan shall develop relationships with the NC START team that is responsible for its Region.
- vii. Telehealth Services
- a) The BH I/DD Tailored Plan is encouraged to use Telehealth as a tool for facilitating access to needed services in a clinically appropriate manner that are not available from providers within the BH I/DD Tailored Plan's State-funded Network.
  - b) The BH I/DD Tailored Plan shall be permitted to leverage Telehealth in its Request for Exception to the Department's BH I/DD Tailored Plan Network adequacy standards, as clinically appropriate.
  - c) The BH I/DD Tailored Plan shall not require a recipient to receive the services via Telehealth if there are other alternatives available.
  - d) Access to Telehealth providers shall not count toward meeting State-funded Network adequacy standards, unless approved as part of an exception to State-funded Network requirements.
- viii. SUD Residential Treatment Services
- a) The BH I/DD Tailored Plan shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VII. Attachment G.2 Required Standard Provisions of BH I/DD Tailored Plan and Provider Contracts for State-funded Services*.
  - b) The Department intends to establish State-funded Network adequacy standards for SUD residential treatment services.
- ix. Furnishing of Services
- a) The BH I/DD Tailored Plan shall meet the State-funded Network time or travel distance and requires State-funded Network providers to meet appointment wait time standards established by the Department as described in *Section VII. Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*, unless otherwise approved by the Department in accordance with the requirements herein.
    - 1. The BH I/DD Tailored Plan shall monitor Network providers regularly to determine compliance with the timely access requirements.
    - 2. The BH I/DD Tailored Plan shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.

3. The Department may amend the State-funded Network time or travel distance, appointment wait time, or other adequacy standards from time-to-time. BH I/DD Tailored Plan shall comply with the new standards as directed, but with no less than a ninety (90) Calendar Day prior notice.
- b) The BH I/DD Tailored Plan shall meet and require its State-funded Network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services. The BH I/DD Tailored Plan shall ensure that State-funded Network providers offer hours of operation that are not less than the hours of operation offered to Medicaid members.
    1. The Department may require after hours and weekend hours to address the needs of the recipient.
  - c) The BH I/DD Tailored Plan shall ensure that covered services are available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
  - d) The BH I/DD Tailored Plan shall ensure that State-funded Network providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all recipients with relevant physical or BH I/DD needs.
  - e) The BH I/DD Tailored Plan shall promote the delivery of services by State-funded Network providers in a Culturally and Linguistically Competent manner to all recipients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation or gender identity.
    1. The BH I/DD Tailored Plan shall assist providers with meeting these requirements including educating providers about the availability of the Cultural and Linguistic Competency resources, how to access the resource, the provider's responsibility in providing access to interpreter services, and the provider's responsibility for having sufficient interpreter capacity.
    2. The BH I/DD Tailored Plan shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.
    3. The BH I/DD Tailored Plan shall ensure that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) recipients who received covered services are not subject to treatment or bias that does not affirm their orientation.
  - f) The BH I/DD Tailored Plan is encouraged to contract with providers outside of the BH I/DD Tailored Plan's Region to ensure services are available to meet recipients' accessibility needs.
  - g) An individual recipient's accessibility and BH I/DD Tailored Plan's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.
- x. Exceptions to Network Requirements
- a) State-funded Network adequacy measures ensure the BH I/DD Tailored Plan's ability to deliver the services promised by providing reasonable access to a sufficient number of in-network psychiatrists, and all BH, I/DD and TBI services included under the terms of the Contract. Recognizing that there are circumstances which cannot be remedied by the BH I/DD Tailored Plan's alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to State-funded Network requirements in a time-limited manner. However, the Department shall partner with BH I/DD Tailored Plans to find innovative ways to develop or foster provider capacity or otherwise meet the network requirements of State-funded Services.
  - b) The BH I/DD Tailored Plan may request Department approval for an exception to meeting the State-funded Network adequacy standards in a specific Region for a specific provider type. Requests must:
    1. Be made in writing;

2. Describe efforts to negotiate in good faith;
  3. Include justification for the exception and a description of how State-funded Services recipient needs for the specific Region and provider type will be met; and
  4. Include the BH I/DD Tailored Plan's plan to address recipient needs and remedy the network deficiency, including an estimated time-line to close the network gap.
- c) The Department's approval of an exception request to the BH I/DD Tailored Plan Network adequacy standards will be limited to a specific time frame. Forty-five (45) Calendar Days before an exception/alternative arrangement is set to expire, the BH I/DD Tailored Plan shall submit a new request for the exception/alternative arrangement or inform the Department the exception/alternative arrangement is no longer needed.
- xi. Assurances of Adequate Capacity and Services
- a) The BH I/DD Tailored Plan shall develop a Network Access Plan for both Medicaid and State-funded Services and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's BH I/DD Tailored Plan Network adequacy standards (as found *Section VII. Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*), federal and state law where applicable, and the terms of this Contract.
1. The BH I/DD Tailored Plan's Network Access Plan must:
  2. Demonstrate compliance, or submit plans for compliance before launch of BH I/DD Tailored Plan, with all the following components:
    - a) Maintains a State-funded Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of State-funded Services recipients in the Region.
    - b) Include procedures to address the following:
      - 1) Referrals;
      - 2) Disclosures and notices to recipients of BH I/DD Tailored Plan services and features; and
      - 3) Coordination and continuity of care.
  3. Demonstrate the BH I/DD Tailored Plan's efforts to:
    - a) Address the needs of all recipients, including those with limited English proficiency or illiteracy;
    - b) Address the needs of historically marginalized populations;
    - c) Ensure that State-funded Network providers provide physical access, reasonable accommodations, and accessible equipment for recipients with relevant physical, BH or I/DD needs;
    - d) Assist the Department, as directed, to assess the capacity of select providers to ensure that recipients residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:
      - 1) Behavioral health residential treatment facilities licensed under 10A NCAC 27G.1300, .1700, .1900, .3100, .3200, 3400, .4100, .4300, .5600,
      - 2) Adult care homes licensed under 10A NCAC 13F and 13G
    - e) Support and sustain providers, in rural and other traditionally underserved areas as well as providers representative of Historically Marginalized Populations.
  4. Include the BH I/DD Tailored Plan's:
    - a) Efforts to establish a Network that meets the State-funded Network adequacy standards.

- b) Quantifiable and measurable process for monitoring and assuring the sufficiency of the State-funded Network to meet the health care needs of all recipients on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a month.
- c) Factors used to build the State-funded Network, including a description of the criteria used to select providers for the network.
- d) Process and methodology to understand the distribution of recipient health care needs against available providers and provider capacity to serve those needs.
- e) Plan to provide in-network access, compliant with the Department's State-funded Network adequacy standards, to children to the full range of age-appropriate BH and I/DD providers:
  - 1) Method for ensuring children's BH and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in child health development, and
  - 2) Approach to assure children's access to child psychologists and child and adolescent psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).
- f) Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
- g) Geographical location of providers in the State-funded Network in relation to where recipients reside.
- h) The BH I/DD Tailored Plan shall describe how it will address Cultural and Linguistic Competency for specific populations, such as people with TBI, people with disabilities, people who are blind or visually impaired, people who are deaf or hard of hearing, recipients who are in the Armed Services, veterans and their families, pregnant women with SUD, people who identify themselves as LGBTQ+, people who are in jails or prisons, youth in the juvenile justice system, justice-involved populations more broadly, HMPs, and other vulnerable populations.
- i) Strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:
  - 1) Ambulatory detoxification, substance abuse non-medical community residential treatment, substance abuse medically monitored residential treatment, and SUD residential recovery services and supports, medication assisted treatment and adolescent SUD treatment services, including how the BH I/DD Tailored Plan shall analyze and monitor utilization of these services, develop clinical practice guidelines related to appropriate utilization of these services, configure a continuum of access to these services, pursue other efforts to enhance access and develop provider capacity for these services;
  - 2) First episode psychosis programs (FEP), including how the BH I/DD Tailored Plan shall: analyze and monitor utilization of FEPs, develop clinical practice guidelines related to appropriate utilization of FEP and educate and train providers, and pursue efforts to enhance access and develop FEP capacity with a focus on recipients between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect

recipients to existing programs, conduct active surveillance of those at-risk); and

- 3) Case management services for recipients with behavioral health conditions, including how the BH I/DD Tailored Plan shall analyze and monitor utilization of these services, develop clinical practice guidelines related to appropriate utilization of these services, pursue other efforts to enhance access and develop provider capacity for these services.
  5. The Network Access Plan must be provided as follows:
  6. Thirty (30) Calendar Days after Contract Award;
  7. As specified by the Department;
  8. Annually; and
  9. Within thirty (30) Calendar Days of a Significant Change, including merger or county disengagement.
  10. The demonstration shall be that the BH I/DD Tailored Plan has the capacity to serve the expected number of recipients on a regional basis.
  11. The Network Access Plan shall be subject to Department review and approval. The BH I/DD Tailored Plan shall amend the Network Access Plan as directed by the Department.
- b) Ongoing Monitoring and Significant Changes in the Provider Network
1. At least once a month, the BH I/DD Tailored Plan shall monitor its Provider Network for a Significant Change that would affect the adequacy or capability or services and compliance with the time/distance and appointment wait time standards established by the Department as described in *Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*.
  2. Within five (5) Business Days of identifying a Significant Change that impacts network adequacy and the ability to provide services, the BH I/DD Tailored Plan shall provide notice to the Department in a format and manner as determined by the Department.
  3. Within thirty (30) Calendar Days of submission of the notice of a Significant Change, the BH I/DD Tailored Plan shall submit to the Department:
  4. An updated Network Access Plan, including an updated attestation of compliance with the time/ distance and appointment wait time standards established by the Department;
  5. An updated Network data file as required under *Section V.C.4.a. Provider Network*; and
  6. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.
- c) The BH I/DD Tailored Plan and its Network providers shall comply and cooperate with DMH/DD/SAS and DHHS vendors during annual validation activities of the BH I/DD Tailored Plan's State-funded network and compliance with State-funded network requirements.

b. Provider Network Management

- i. The BH I/DD Tailored Plan shall manage its State-funded Network to meet availability, accessibility, and quality goals and requirements. The BH I/DD Tailored Plan shall have a strong monitoring program to ensure providers are meeting recipient needs and program requirements.
- ii. To help recognize the Department's aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized State-funded Services provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the PDM/CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the Medicaid provider enrollment process including the collection and verification of provider education, training, experience and competency. The period before the PDM/CVO has achieved full implementation will be considered the "Provider Credentialing Transition Period." The

information gathered by the Department will be shared with the BH I/DD Tailored Plan, which will use that information for network contracting. State-funded Services providers are not required to enroll in Medicaid but will be subject to the Department's centralized credentialing process and the collection and verification of provider qualification requirements through this process.

iii. Provider Contracting

- a) The BH I/DD Tailored Plan's contracts with State-funded providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses listed in *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*.
- b) The BH I/DD Tailored Plan shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) Calendar Days after the Contract Award.
  1. The BH I/DD Tailored Plan may utilize proposed contract templates submitted as part of the Applicant's Application Proposal prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
  2. Upon approval by the Department, the BH I/DD Tailored Plan shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The BH I/DD Tailored Plan shall discontinue use of previously submitted contract templates once an amended version is approved.
  3. The BH I/DD Tailored Plan shall submit newly developed contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers.
  4. During contract negotiations with a provider, the BH I/DD Tailored Plan may, without the Department's prior approval, make amendments to a previously approved provider contract template.
    - a) Any change to a standard provision required by *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, is limited to those provisions outlined in *Section VII. Attachment G.2.* except for a change to a provision related to subsections 1.w., 1.x., 1.y., or 1.z., which must be prior approved by the Department.
    - b) Any change to a standard provision required in *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, must be prior approved by the Department.
    - c) Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.
- c) The BH I/DD Tailored Plan may only make changes to the provisions required in *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, when directed to do so by the Department. The BH I/DD Tailored Plan shall not employ or contract with any provider appearing on one of the Exclusion Lists.
- d) The BH I/DD Tailored Plan shall offer to contract with a provider in writing.
  1. All offers shall include the standard provisions for provider contracts found in *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, including the prescribed provisions located therein.
  2. If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the BH I/DD Tailored Plan may consider the request for inclusion in the State-funded Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the BH I/DD Tailored Plan shall not consider the request rejected.

3. The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers, including non-medical service providers, or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan.
- e) The BH I/DD Tailored Plan may require individual practitioners, as a condition of contracting with the BH I/DD Tailored Plan for State-funded Services, to agree to participate in the BH I/DD Tailored Plan's Medicaid network. The BH I/DD Tailored Plan shall not automatically enroll the provider in any other product offered by BH I/DD Tailored Plan. This requirement shall not apply to facility providers. The BH I/DD Tailored Plan shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the BH I/DD Tailored Plan's final decision. The notice shall include the reason for the BH I/DD Tailored Plan's decision, the Provider's right to appeal that decision, and how to request an appeal.
  - f) The BH I/DD Tailored Plan shall, with regard to payment to any provider or Subcontractor that is "related to" the BH I/DD Tailored Plan, comply with the requirements in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
  - g) Provider contracts shall specify the federal aid category when federal funds are utilized to reimburse the provider.
  - h) The BH I/DD Tailored Plan shall include in contracts with providers the responsibility for compliance with service record documentation and retention in accordance with *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
  - i) If the BH I/DD Tailored Plan is notified that a contracted provider has abandoned records, the BH I/DD Tailored Plan shall submit a formal report to the Department.
  - j) If the BH I/DD Tailored Plan is notified that a contracted provider has potentially violated State or federal laws, rules or regulations governing health information privacy and security including but not limited to the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, 110 Stat. 1938 ("HIPAA"), as amended by title XIII of Division A and title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), 45 CFR Parts 160, 162 and 164 (HIPAA Privacy and Security Rule), and N.C. Gen. Stat. §§ 122C-52 through 122C-56, the BH I/DD Tailored Plan shall notify the provider in writing of the potential violation and monitor and follow up with the provider regarding any required compliance steps such as risk assessments, mitigation efforts, notification of affected individuals, and submission of reports to the Department or the US Department of Health and Human Services, Office of Civil Rights.
  - k) If a provider's contract is terminated or if the provider closes network operations, but continues to have operations elsewhere in the state, the BH I/DD Tailored Plan shall permit the provider to provide copies of medical records of individuals to the BH I/DD Tailored Plan or submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall retain the sole discretion to approve or disapprove such a plan.
  - l) The BH I/DD Tailored Plan shall perform the following activities as soon as the BH I/DD Tailored Plan is made aware of the abandonment of any medical records of individuals served pursuant to this Contract in their Region:
    1. The BH I/DD Tailored Plan shall notify the applicable Department Division(s) based on funding source and licensure, i.e. NC Medicaid, DMH/DD/SAS and/or DHSR.
    2. The BH I/DD Tailored Plan shall contact the provider via trackable mail informing them of their report to the Department regarding the abandonment.
    3. The BH I/DD Tailored Plan shall secure the records and complete an inventory log of the records.

- m) The BH I/DD Tailored Plan shall include in contracts with providers the responsibility for compliance with service record documentation and retention in accordance with *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
- n) The BH I/DD Tailored Plan shall include a provision in the provider contract regarding a provider's right to file a grievance or appeal (as described in *Section V.C.4.e. Provider Grievances and Appeals*) in its contract with providers. The BH I/DD Tailored Plan shall include a notice in all provider contracts that the internal appeal process with the BH I/DD Tailored Plan must be completed before seeking other legal or administrative remedies under federal or state law.
- o) The BH I/DD Tailored Plan shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is their patient regarding:
  - 1. The recipient's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - 2. Any information the recipient needs to decide among all relevant treatment options.
  - 3. The risks, benefits, and consequences of treatment or non-treatment.
  - 4. The recipient's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- p) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires providers notify the BH I/DD Tailored Plan when a recipient in a high acuity clinical setting is being discharged.
- q) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires providers transmit a recipient's eligibility information the BH I/DD Tailored Plan. Information may include insurance status and income level.
- r) The BH I/DD Tailored Plan may utilize evergreen contracts (i.e. a contract that automatically renews), with State-funded providers on the condition that the contract also includes the reasons the contract may be terminated or non-renewed.
- s) The BH I/DD Tailored Plan shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.
- t) In contracting with providers, the BH I/DD Tailored Plan shall comply with all applicable Chapter 58 statutes in accordance with *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*.
- u) The BH I/DD Tailored Plan shall include in provider contracts that State-funded Services Participating Providers shall not submit claim or encounter data for services covered by BH I/DD Tailored Plans as State-funded Services directly to the Department.
- v) DSOHF Facilities
  - 1. The BH I/DD Tailored Plan shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the facilities:
  - 2. Julian F Keith ADATC;
  - 3. R.J. Blackley ADATC;
  - 4. Lakeside;
  - 5. Woodside Treatment Center;
  - 6. Cherry Hospital;
  - 7. Broughton Hospital;
  - 8. Central Regional Hospital;
  - 9. Caswell Developmental Center;
  - 10. J. Iverson Riddle Developmental Center;
  - 11. Murdoch Developmental Center; and

12. Whitaker Psychiatric Residential Treatment Facility.
  13. The BH I/DD Tailored Plan shall consider these DSOHF facilities to have met the BH I/DD Tailored Plan's network contracting criteria based on the DSOHF facility's successful completion of the State's Centralized Credentialing and Re-credentialing Process (CCRP) and valid enrollment as a provider in the NC Medicaid program.
  14. The BH I/DD Tailored Plan shall use a Department-developed contract template to contract with these DSOHF facilities to be delivered after Contract Award.
- iv. Critical Incident Reporting
    - a) The BH I/DD Tailored Plan shall establish a process for timely identification, response, reporting, and follow-up to recipient incidents.
    - b) The BH I/DD Tailored Plan shall require contracted providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System.
    - c) The BH I/DD Tailored Plan shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of recipients.
    - d) The BH I/DD Tailored Plan shall report information on incidents and deaths in accordance with Department procedures.
    - e) The BH I/DD Tailored Plan shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-Funded Services.*
    - f) The BH I/DD Tailored Plan shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
    - g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for recipients obtaining services in a DSOHF facilities as detailed in *Section VII. Attachment N. Addendum for Division of State Operated Health Care Facilities Providers.*
  - v. Program Integrity
    - a) The BH I/DD Tailored Plan shall develop policies and procedures to perform monitoring and auditing of provider payment. The BH I/DD Tailored Plan shall provide those policies and procedures to the Department upon request for review, or as otherwise required by this Contract.
    - b) The BH I/DD Tailored Plan shall require State-funded Network providers and out-of-network providers to have policies and procedures that recognize and agree that State-funded Services as "the payer of last resort."
  - vi. Credentialing and Re-credentialing Process
    - a) The BH I/DD Tailored Plan shall develop a Credentialing and Re-credentialing Policy consistent with the Department requirements and its associated policies and subject to Department approval.
      1. The BH I/DD Tailored Plan shall develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.
    - b) The BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval. The BH I/DD Tailored Plan is not prohibited from collecting other information from providers necessary for the BH I/DD Tailored Plan's contracting process.
    - c) The BH I/DD Tailored Plan shall make timely referrals to the State-funded Provider Network Participation Committee, as defined in *Section VII. Attachment M.7. Uniform Credentialing and*

*Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers*, of providers who have been identified as potential network providers. The referral shall include all credentialing and verified information pertaining to the provider as provided by the Department.

- d) The BH I/DD Tailored Plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.C.4. Providers*.
  - e) The BH I/DD Tailored Plan is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in State-funded Services without the express, written consent of the provider or the Department.
  - f) Re-credentialing:
    - 1. During the Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall apply the Department's applicable Objective Quality Standards for participation as a State-funded Services Enrolled provider to contracted providers as a provider is re-enrolled through the Provider Enrollment process.
    - 2. After the Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall apply the Department's applicable Objective Quality Standards for participation as a State-funded Services enrolled provider to contracted providers every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
  - g) Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all BH I/DD Tailored Plan State-funded Network providers.
    - 1. The BH I/DD Tailored Plan may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) Calendar Days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) Calendar Day period without enrollment of the provider, and notify affected recipients.
  - h) The BH I/DD Tailored Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.
  - i) Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section III.C.5. Availability of Funds*, the Department shall indemnify, defend, and hold harmless the BH I/DD Tailored Plan, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the BH I/DD Tailored Plan by the Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the BH I/DD Tailored Plan and relied upon by the BH I/DD Tailored Plan in credentialing a provider for participation in the BH I/DD Tailored Plan's network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The BH I/DD Tailored Plan shall have the option to participate at its own expense in the defense of such claims or actions filed and the BH I/DD Tailored Plan shall be responsible for its own litigation expenses if it exercises this option. In no event shall the BH I/DD Tailored Plan be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The BH I/DD Tailored Plan shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the BH I/DD Tailored Plan's use of and reliance on such credentialing information.
- vii. Network Provider System Requirements

- a) The BH I/DD Tailored Plan shall accurately and timely load into the BH I/DD Tailored Plan's claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.
  - b) Unless otherwise written in the contract, the BH I/DD Tailored Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a State-funded Service or item already provided to a recipient and billed to the BH I/DD Tailored Plan by the provider:
    - 1. Newly credentialed provider attached to a new contract within ten (10) Business Days after completing contracting;
    - 2. Newly credentialed hospital or facility provider attached to a new contract within fifteen (15) Business Days after completing contracting;
    - 3. Newly credentialed provider attached to an existing contract within five (5) Business Days after completing contracting;
    - 4. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) Business Days after completing receipt of notification of the change through the Department;
    - 5. Change in existing contract terms within ten (10) Business Days of the effective date after the change; and
    - 6. Changes in provider service location or demographic data or other information related to recipient's access to services must be updated no later than thirty (30) Calendar Days after the BH I/DD Tailored Plan receives updated provider information.
  - c) Payment should be made on the next payment cycle following the requirement outlined above.
  - d) In no case shall a provider be loaded into the Provider Directory during a timeframe in which the provider cannot receive payment in accordance with the BH I/DD Tailored Plan's current payment cycle.
- viii. Network Provider Credentialing and Re-credentialing Policy
- a) The BH I/DD Tailored Plan shall establish and follow written policies and procedures for State-funded Network provider selection and retention. The BH I/DD Tailored Plan shall apply these criteria consistently to all providers. The BH I/DD Tailored Plan shall develop and maintain a Network Provider Credentialing and Re-credentialing Policy as defined in *Section VII. Attachment M.7. Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers.*
  - b) The BH I/DD Tailored Plan shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) Calendar Days after the Contract Award. The Policy must be approved by the Department at least sixty (60) Calendar Days prior to executing contracts with providers.
    - 1. The BH I/DD Tailored Plan may utilize the draft Credentialing and Re-credentialing Policy submitted as part of the Applicant's Application Proposal prior to approval by the Department with notification to the provider that the Credentialing and Re-credentialing Policy is subject to amendment based upon Department review and approval.
  - c) The BH I/DD Tailored Plan shall submit any significant policy changes to the Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.
  - d) Provider Network Participation Committee
    - 1. The BH I/DD Tailored Plan shall establish and maintain a Provider Network Participation Committee to make network contracting determinations in accordance with BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy.

2. The BH I/DD Tailored Plan's Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.
  3. The BH I/DD Tailored Plan shall make network contracting decisions within the following timeframes:
  4. For ninety percent (90%) of providers within thirty (30) Calendar Days of the Committee's receipt of complete credentialing and verified information for consideration; and
  5. For one hundred percent (100%) of providers within forty-five (45) Calendar Days of the Committee's receipt of complete credentialing and verified information for consideration.
  6. The BH I/DD Tailored Plan shall provide written notice of network contracting decisions to providers within five (5) Business Days of the Provider Network Participation Committee's determination.
- e) Provider Disenrollment and Termination
1. Payment Suspension at Re-Credentialing:
  2. The BH I/DD Tailored Plan shall suspend claims payment to any provider in its network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.
  3. The BH I/DD Tailored Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) Calendar Days of suspension, the Department will terminate the provider from its State-funded provider network.
  4. The BH I/DD Tailored Plan shall not be liable for interests or penalties for payment suspension at re-credentialing.
  5. The BH I/DD Tailored Plan shall address payment suspension at re-credentialing in its Network Provider Credentialing and Re-credentialing Policy.
  6. Termination as a State-funded Services Provider by the Department:
  7. The BH I/DD Tailored Plan shall remove any provider from the claims payment system and terminate the provider's contract within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a State-funded Services provider. This applies to all providers regardless of the provider's network status.
  8. If the BH I/DD Tailored Plan suspended provider payment, then upon notice by the Department that the provider is terminated from State-funded Services, the BH I/DD Tailored Plan shall release applicable claims and deny payment for dates of service after the date of termination from the State-funded Services network.
  9. BH I/DD Tailored Plan Provider Termination
  10. The BH I/DD Tailored Plan may terminate a provider from its State-funded Network with cause. Any decision to terminate must comply with the requirements of the Contract.
  11. The BH I/DD Tailored Plan shall comply with the program integrity provider termination requirements outlined in *Section V.A.3.ii. Program Integrity for Medicaid and State-funded Services*.
  12. The BH I/DD Tailored Plan must provide written notice to the Network provider of the decision to terminate to the provider. The notice, at a minimum, must include:
    - a) The reason for the BH I/DD Tailored Plan's decision;
    - b) The effective date of termination;
    - c) The provider's right to appeal the decision; and
    - d) How to request an appeal.

13. The BH I/DD Tailored Plan shall report data to the Department on the number of providers terminated by provider type in a format dictated by the Department for the Network Access Report identified in *Section VII. Attachment J. Reporting Requirements*.
  14. Recipient Notice of Provider Disenrollment/Termination
  15. The BH I/DD Tailored Plan shall notify each recipient who, at a minimum was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the State-funded Network. The BH I/DD Tailored Plan shall:
    - a) Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the BH I/DD Tailored Plan.
- ix. Provider Directory
- a) The BH I/DD Tailored Plan shall develop a consumer-facing provider Network Directory of all State-funded Network providers including the required information for all such providers.
  - b) The Network Directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance the Contract, and as specified by Department.
  - c) The BH I/DD Tailored Plan shall ensure that the consumer-facing Network Directory:
    1. Be in a format that is machine-readable and readily accessible;
    2. Is placed in a location on the BH I/DD Tailored Plan's website that is prominent and readily accessible by recipients;
    3. Includes accurate and updated provider information, including fidelity evaluation scores, consistent with Contract requirements;
    4. Is provided in an electronic form which can be electronically retained and printed; and
    5. Is available in paper form without charge upon recipient request and if requested, is provided within five (5) Business Days.
  - d) The BH I/DD Tailored Plan shall update:
    1. The paper directory at least monthly and clearly identify the date of the update; and
    2. The electronic version of the consumer-facing directory no later than ten (10) Business Days after the BH I/DD Tailored Plan receives updated provider information and clearly identify the date of the update.
  - e) The BH I/DD Tailored Plan shall provide the Department with a copy of both the electronic and paper versions of the Network Directory as follows:
    1. At the request of the Department during the Readiness Review;
    2. Annually; and
    3. Any time there has been a Significant Change in BH I/DD Tailored Plan operations that impacts the content of the directory.
  - f) The BH I/DD Tailored Plan shall provide the Department with the following information, at a minimum, in a format to be prescribed by the Department:
    1. Provider name;
    2. Provider demographics (first, middle, and last name, gender);
    3. Providers 3-digit Location Code;
    4. Provider DBA Name;
    5. Provider Service Location Name;
    6. Provider mailing address;
    7. Provider type;
    8. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
    9. Street address(as) of service location(s);
    10. County(ies) of service location(s);
    11. Telephone number(s) at each location;

12. After hours telephone number(s) at each location;
  13. Website URL(s);
  14. Services provided at the location
  15. Whether BH provider is serving children and adolescents;
  16. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
  17. Whether provider has completed Cultural and Linguistic Competency training;
  18. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
  19. A telephone number at the BH I/DD Tailored Plan where a recipient can call to confirm the information in the directory;
  20. Excluded provider indicator; and
  21. Contract start/end date.
- c. Provider Relations and Engagement
- i. Providers are critical partners in ensuring that State-funded Services are readily accessible to recipients. The Department seeks a BH I/DD Tailored Plan that will engage and support providers through a call center and online provider portal as well as provide training and education on State-funded Services and providers' rights within the program.
  - ii. Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
    - a) The BH I/DD Tailored Plan shall operate a Provider Relations function that includes a Provider Support Service Line consistent with the applicable standards found in *Section V.A.2. Program Operations*. The Provider Support Service Line shall comply with the requirements set forth in *Section V.A.1.iv . Third Party (Subcontractor) Contractual Relationships* if the BH I/DD Tailored Plan use a Subcontractor to provide or operate the service line (see V.A.2.a. Service Lines for Medicaid and State-funded Services).The BH I/DD Tailored Plan shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web portal may include access to the Provider Manual.
    - b) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) Calendar Days of executing a contract with the Provider for participation in its State-funded Network. The Provider Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.
    - c) The BH I/DD Tailored Plan shall develop and maintain a Provider Support Plan as described in *Section V.C.5.a. Quality Management and Quality Improvement* and make it available to Department upon request.
  - iii. Provider Education and Training
    - a) The BH I/DD Tailored Plan shall provide education specific to the State-funded Services requirements, policies and procedures, as well as training and technical assistance on all BH I/DD Tailored Plan-specific administrative and clinical policies and requirements to State-funded Network providers.
    - b) The BH I/DD Tailored Plan shall communicate with State-funded Network providers, or include in its training and technical assistance, information as requested by Department.
    - c) The BH I/DD Tailored Plan shall provide training to State-funded Network providers within thirty (30) Calendar Days of a provider joining the Network. Additional training will be provided as determined by the BH I/DD Tailored Plan and as requested by Department.
    - d) The BH I/DD Tailored Plan shall make training materials available on the provide Web portal as determined appropriate by the BH I/DD Tailored Plan and upon request by State-funded Network providers or Department.

- e) The BH I/DD Tailored Plan shall develop a Provider Training Plan that outlines training topics and dates. The BH I/DD Tailored Plan Provider Training Plan shall reference and acknowledge the broader role the BH I/DD Tailored Plan has in supporting Department initiatives.
  - f) The BH I/DD Tailored Plan shall submit the Provider Training Plan to the Department as follows:
    - 1. Upon award of this contract;
    - 2. When material changes are made to the Provider Training Plan; and
    - 3. Annually.
- iv. Provider Manual
- a) The BH I/DD Tailored Plan shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the BH I/DD Tailored Plan and State-funded Services. At a minimum, the Provider Manual must cover the following subject matter:
    - 1. Covered services;
    - 2. Eligibility for state-funded services
    - 3. Care management (including in-reach, transition management and diversion) delivered through the BH I/DD Tailored Plans;
    - 4. UM program;
    - 5. Provider responsibilities;
    - 6. Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
    - 7. Telehealth;
    - 8. Network adequacy and access standards;
    - 9. Billing, claim editing, SNIP editing and clearinghouse requirements;
    - 10. Cultural and Linguistic Competency and accessibility requirements;
    - 11. Care management and discharge planning requirements;
    - 12. Department-required documentation requirements;
    - 13. Provider appeals and grievance process;
    - 14. Complaint or grievance investigation and resolution procedures;
    - 15. Performance improvement procedures including recipient satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
    - 16. Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of services requirements;
    - 17. Interest and liquidated damages provisions for late or under-payment by the BH I/DD Tailored Plan;
    - 18. Recipient rights and responsibilities;
    - 19. Recipient cost sharing requirements; and
    - 20. Provider program integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other state and federal requirements.
  - b) The BH I/DD Tailored Plan shall also include in the Provider Manual providers' obligations to:
    - 1. Monitor and audit provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
    - 2. Retain patient records for the mandated period;
    - 3. Ensure that all documentation regarding services provided is timely, accurate, and complete;
    - 4. Ensure BH I/DD Tailored Plan for State-funded Services is the payer of last resort; and
    - 5. To report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment.

- c) The BH I/DD Tailored Plan shall include standardized language in the Provider Manual as requested by the Department.
  - d) The BH I/DD Tailored Plan shall submit Provider Manual to Department for approval thirty (30) Calendar Days after Contract Award. The BH I/DD Tailored Plan shall not use or distribute the Provider Manual prior to approval by Department.
  - e) The BH I/DD Tailored Plan shall regularly review and update the Provider Manual to reflect changes to applicable state laws, rules and regulations, Department or BH I/DD Tailored Plan policies, procedures, bulletins, guidelines or manuals, or BH I/DD Tailored Plan business processes as necessary.
  - f) The BH I/DD Tailored Plan shall submit the Provider Manual to Department for approval within fifteen (15) Calendar Days of making substantive updates or revisions.
  - g) The BH I/DD Tailored Plan shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) Calendar Days of notification or request by Department. Corrections or revisions to the printed version must be included in the next printing.
  - h) The BH I/DD Tailored Plan shall make the Provider Manual available in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
- v. Provider Survey
- a) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Provider Relations staff via standardized provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary. The BH I/DD Tailored Plan shall:
    - 1. Make provider surveys available after each web, call center or in-person interaction;
    - 2. Conduct surveys and internal audits intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and perception of the call center/website convenience and effectiveness; and
    - 3. Provide reports, including the results of provider surveys and BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- d. Provider Payments
- i. Provider payment requirements are established to comply with State law, encourage continued provider participation in the State-funded BH, I/DD and TBI services Network to ensure recipient access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of BH I/DD Tailored Plan steerage to other providers.
  - ii. The BH I/DD Tailored Plan shall assist the Department in complying with all federal laws, state laws, PI or audit requirements, investigations, findings or corrective action plans related to provider payments.
  - iii. The BH I/DD Tailored Plan shall timely reimburse providers for duly authorized services provided and billed, contingent upon receipt of timely payments from the Department.
  - iv. The BH I/DD Tailored Plan shall institute the following provider reimbursement policies for State-funded Services:
    - a) All payments for services to providers shall be subject to review and audit for their conformity with applicable state and federal laws, rules and regulations and requirements contained in any applicable contract between the BH I/DD Tailored Plan and the provider.
    - b) The BH I/DD Tailored Plan may use different reimbursement methodologies or reimburse at amounts for different specialties or for different practitioners in the same specialty; and will

- establish measures that are designed to maintain quality of services and control cost consistent with its responsibilities to recipients.
- c) The BH I/DD Tailored Plan may establish rates specific to a provider, as the BH I/DD Tailored Plan determines necessary and appropriate. The BH I/DD Tailored Plan may offer different rates to different providers offering the same services according to the BH I/DD Tailored Plan's established plan with criteria, such as paying enhanced rates for evidence-based practices or for positive outcomes.
  - d) The BH I/DD Tailored Plan shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any denied claims billed shall be returned to the provider with an explanation for the denial.
- v. State Owned and Operated Facilities Payments
- a) The BH I/DD Tailored Plan shall reimburse facilities that are State-owned and operated by the DSOHF according to the rates established by the Department.
- vi. Payment Limitations
- a) Upon request by the Department, the BH I/DD Tailored Plan shall submit information on payments to related providers and Subcontractors and provide a demonstration of how payment levels for related providers and Subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are value-based payment arrangements in place.
- e. Provider Grievances and Appeals
- i. The BH I/DD Tailored Plan shall handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The BH I/DD Tailored Plan shall have in place a provider appeals and grievance system, distinct from that offered to recipients, that includes a grievance process for providers to bring issues to the BH I/DD Tailored Plan, an appeals process for providers to challenge certain BH I/DD Tailored Plan decisions, and information regarding access to a state level review through the North Carolina Office of Administrative hearings. The BH I/DD Tailored Plan shall be transparent with providers regarding its appeals and grievance processes and procedures. The BH I/DD Tailored Plan shall ensure the Grievances and Appeals system complies with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan delegates any activities to a Subcontractor.
  - ii. The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) Calendar Days after Contract Award. The BH I/DD Tailored Plan shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.
  - iii. The BH I/DD Tailored Plan shall have a process to and staff capable of reviewing provider grievance and appeal outcomes to identify trends, and existing operational or clinical opportunities to improve the provider experience.
  - iv. The BH I/DD Tailored Plan shall not discriminate against or retaliate against any provider based on any action taken by the provider under Provider Grievances and Appeals Section of the Contract or under the recipient appeals process of the Contract taken on behalf of a recipient.
- v. Grievances
- a) The BH I/DD Tailored Plan shall have a process in place to receive and resolve grievances with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
  - b) The BH I/DD Tailored Plan shall accept and resolve provider grievances regarding the BH I/DD Tailored Plan referred from the Department.
  - c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit grievances through the BH I/DD Tailored Plan provider web portal.

- d) The BH I/DD Tailored Plan shall provide information regarding provider grievances to Department in a form and frequency as outlined in *Section VII. Attachment J. Reporting Requirements* and upon request.
- vi. Appeals
- a) The BH I/DD Tailored Plan shall offer providers appeal rights as described in *Section VII. Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Providers*.
  - b) The BH I/DD Tailored Plan shall provide written notice of provider's right to appeal with the notice of decision giving rise to the provider's right to appeal.
  - c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit appeals through the BH I/DD Tailored Plan provider web portal.
  - d) The BH I/DD Tailored Plan shall accept a written request for an appeal from the provider within thirty (30) Calendar Days on which:
    - 1. Provider receives written notice from the BH I/DD Tailored Plan of the decision giving rise to the right to appeal; or
    - 2. BH I/DD Tailored Plan should have taken a required action and failed to take such actions.
  - e) The BH I/DD Tailored Plan shall acknowledge receipt of each appeal request within five (5) Calendar Days of receipt of the request.
  - f) The BH I/DD Tailored Plan shall extend the timeframe by thirty (30) Calendar Days for providers to request an appeal for good-cause shown as determined by the BH I/DD Tailored Plan.
    - 1. BH I/DD Tailored Plan shall document in its Grievances and Appeals Policy its policy and procedure for extending the timeframe for submission of an appeal request.
    - 2. The BH I/DD Tailored Plan shall consider the voluminous nature of required evidence/supporting documentation, and appeal of an adverse quality decision as good-cause reasons to extend the timeframe.
  - g) The BH I/DD Tailored Plan shall provide information regarding provider appeals to Department upon request.
  - h) The BH I/DD Tailored Plan Grievances and Appeals Policy shall provide that a provider must exhaust the BH I/DD Tailored Plan internal appeals process before seeking recourse under any other process permitted by contract or law.
- vii. Resolution of Appeal
- a) The BH I/DD Tailored Plan shall establish a committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal. The committee must include an external peer reviewer when the issue on appeal involves whether the provider met Objective Quality Standards.
  - b) The BH I/DD Tailored Plan shall provide written notice of decision of the appeal within thirty (30) Calendar Days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the BH I/DD Tailored Plan. Notice shall include information regarding further appeal rights, if any.
  - c) The BH I/DD Tailored Plan shall allow providers to be represented by an attorney during the appeals process.
- viii. Appeals of Suspension or Withhold of Provider Payment
- a) The BH I/DD Tailored Plan shall limit the issue on appeal in cases of suspension or withhold or provider payment to whether the BH I/DD Tailored Plan had good-cause to commence the withhold or suspension of provider payment. BH I/DD Tailored Plan shall not address whether the provider has or has not committed fraud or abuse.
  - b) The BH I/DD Tailored Plan shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.

- c) The BH I/DD Tailored Plan shall offer the provider an in-person, telephone, or virtual hearing when provider is appealing whether BH I/DD Tailored Plan has good cause to withhold or suspend payment to the provider.
  - d) The BH I/DD Tailored Plan shall schedule the hearing and issue a written decision regarding whether BH I/DD Tailored Plan had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's appeal. Upon a finding that BH I/DD Tailored Plan did not have good-cause to suspend or withhold payment, BH I/DD Tailored Plan shall reinstate any payments that were withheld or suspended within five (5) Business Days.
  - e) The BH I/DD Tailored Plan shall pay interest and penalties for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.
- ix. Notice to Department
- a) The BH I/DD Tailored Plan shall provide notice to the Department of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by BH I/DD Tailored Plan, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the appeal.
  - b) The BH I/DD Tailored Plan shall notify Department if a provider has sued BH I/DD Tailored Plan in any administrative or general court of justice for actions related to State-funded Services. Such notice must be provided within five (5) Business Days of being served.

5. Quality

a. Quality Management and Quality Improvement

- i. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. For BH I/DD Tailored Plans, which are tasked with caring for North Carolinians with complex BH, I/DD, and TBI needs, the Department intends to incorporate additional standards and opportunities related to the unique aspects of the BH I/DD Tailored Plan State-funded Services population. The Department intends to promote the highest quality of care for BH, I/DD, and TBI needs and to promote integration among BH, I/DD, and TBI providers.
- ii. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. DMH/DD/SAS's Quality Management plan outlines the Division's Quality Management Program, its values, guiding principles and improvement initiatives for providing access to high quality BH, SUD services and I/DD and TBI supports.
- iii. As North Carolina transitions its Medicaid program and State-funded services system to BH I/DD Tailored Plans, the Department will work with the BH I/DD Tailored Plan to develop a data-driven, outcomes-based continuous QI process. The QI process will build upon the Department's experience and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards BH I/DD Tailored Plans and, in turn, providers for advancing quality goals and health outcomes.
- iv. The BH I/DD Tailored Plan shall have an IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations. The BH I/DD Tailored Plan shall engage with the Department and its designees to share quality data reported by the BH I/DD Tailored Plan and receive quality data calculated by the BH I/DD Tailored Plan or its designees.

- v. The BH I/DD Tailored Plan shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and QAPI Plan, and DMH/DD/SAS's Quality Management plan.
  - a) QAPI Plan
    1. The BH I/DD Tailored Plan shall submit an annual QAPI Plan, delineating the BH I/DD Tailored Plan's plans for performance improvement programs and other quality improvement efforts. The Department expects the BH I/DD Tailored Plan to submit a combined QAPI Plan for Medicaid, NC Health Choice, and State-funded services.
    2. The BH I/DD Tailored Plan shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
    3. The QAPI plan shall include the following elements for State-funded services:
    4. If the BH I/DD Tailored Plan intends to implement a PIP specified by the Department that are relevant to State-funded Services, a discussion of how the PIP will promote high-quality State-funded Services;
    5. Collection and submission of all quality performance measurement data required by the Department;
    6. Mechanisms to detect both underutilization and overutilization of services;
    7. Mechanisms to assess the quality and appropriateness of care for recipients;
    8. Mechanisms to assess the quality and appropriateness of care provided to recipients needing home and community-based services for BH, I/DD, and TBI, including assessment of care between settings and a comparison of services and supports received with those set forth in the recipient's treatment/service plan;
    9. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group;
    10. Participation in efforts by the Department to prevent, detect, and remediate critical incidents; and
    11. Mechanisms to assess and address health disparities, including findings from the disparity report that BH I/DD Tailored Plans are required to develop.
    12. The BH I/DD Tailored Plan shall participate in monthly BH I/DD Tailored Plan Quality Director Meetings.
    13. The BH I/DD Tailored Plan shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.
    14. The BH I/DD Tailored Plan shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of each BH I/DD Tailored Plan's overall QAPI program design as directed by the Department.
    15. If the BH I/DD Tailored Plan selects a PIP that is relevant to its State-funded Services recipients, it should report its performance on quality measures that apply to both Medicaid and State-funded populations separately for each population.
  - vi. Quality Measures
    - a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in *Section VII. Attachment E.2. BH I/DD Tailored Plan Quality Metrics for State-funded Services* that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and financial accountability for a select set of measures to be specified by the Department.

- b) The BH I/DD Tailored Plan shall calculate and report on those measures identified by the Department in *Section VII. Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*. The Department will monitor other measures that are not designated in *Section VII. Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*, and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance reports. The Department reserves the right to add, remove, or modify measures in *Section VII. Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*.
  - c) The BH I/DD Tailored Plan is financially accountable for measures indicated in *Section VI.A. Table 3: State-funded BH I/DD Tailored Plan Liquidated Damages for Performance Measures*. The Department reserves the right to add, remove, or modify measures in *Section VI.A. Table 3: State-funded BH I/DD Tailored Plan Liquidated Damages for Performance Measure*.
  - d) The BH I/DD Tailored Plan shall incorporate populations receiving State-funded Services into measures included in *Section VII. Attachment E: Tables 1-6 Survey Measures and General Measures for Medicaid* where applicable and shall stratify results of these measures to distinguish between Medicaid members and State-funded Services recipients.
  - e) The BH I/DD Tailored Plan shall submit to the Department all data necessary for the Department to calculate the BH I/DD Tailored Plan's performance on State-funded Services measures.
  - f) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plans prior to launch and annually thereafter.
  - g) The BH I/DD Tailored Plan shall, where applicable, incorporate populations receiving State-funded Services into their QAPI and quality improvement activities.
- vii. Measurement of Outcomes
- a) The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas of quality of life, functional status assessment and recipient satisfaction. This measurement will involve the use of surveys that may be administered by providers or third-party contractors and may involve the development and piloting of novel survey instruments.
  - b) The BH I/DD Tailored Plan shall support the administration of surveys as requested by the Department. This support may include conducting outreach to members and providers, incorporating in provider contracting requirements related to survey administration, and conducting analysis of internal data to support survey piloting.
  - c) The BH I/DD Tailored Plan shall ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department.
  - d) The Department is also exploring administrative data from other State agencies to support measurement of outcomes outside of the health care system for State-funded services recipients.
- viii. Disparities Reporting and Tracking
- a) The BH I/DD Tailored Plan shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
  - b) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plan after Contract Award and annually thereafter.
  - c) The BH I/DD Tailored Plan shall address inequalities as determined by the Department during review of the BH I/DD Tailored Plan's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.

- d) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.
  - ix. The BH I/DD Tailored Plan shall be an active partner in Healthy NC 2030 (<https://nciom.org/healthy-north-carolina-2030/>) goals' planning by participating at a minimum as follows:
    - a) Joining planning meetings;
    - b) Designating a senior level clinical staff person to engage in public health issue discussions; and
    - c) Aligning QI activities to support Healthy NC 2030 goals.
  - x. Public Health Reporting and Tracking
    - a) The BH I/DD Tailored Plan shall work with the Department to target areas of collaboration and develop programs as part of Quality Improvement efforts that can:
      - 1. Remove barriers (e.g., services coverage, implementation challenges, recipient education);
      - 2. Require select quality initiatives to be embedded in QAPIs, including PIPs.
  - xi. Performance Improvement Projects (PIPs)
    - a) For Medicaid and NC Health Choice, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program. See *Section V.B.5.i.(xiii) Performance Improvement Projects*. The BH I/DD Tailored Plan is not required to conduct separate PIPs related to State-funded Services, but rather to incorporate State-funded Services into any PIP it conducts that is in a related area. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in the document.
    - b) To the extent that the BH I/DD Tailored Plan's Medicaid and NC Health Choice PIPs apply to non-clinical and clinical areas relevant to State-funded services, the BH I/DD Tailored Plan shall include State-funded services and recipients in the PIP. The BH I/DD Tailored Plan shall ensure the PIP:
      - 1. Is designed to achieve significant improvement in health outcomes as part of the annual BH I/DD Tailored Plan QAPI program review; and
      - 2. Includes measurement of performance using quality indicators as part of the annual BH I/DD Tailored Plan QAPI program review.
  - xii. External Quality Review
    - a) The BH I/DD Tailored Plan shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO. This may include a consolidated approach assessing both Medicaid and State-funded Services.
    - b) The BH I/DD Tailored Plan shall participate in the annual the Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS), CAHPS-ECHO and Provider Survey conducted by the EQRO, and other surveys as required by the Department.
6. Claims Management
- a. Provider Claims
    - i. Claims Processing and Reprocessing Standards
      - a) The BH I/DD Tailored Plan shall have the automated capability to identify, process, and reprocess claims as required by this Contract. Prior to paying a claim, the BH I/DD Tailored Plan shall validate that the provider is eligible to be paid by the Department.
      - b) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the BH I/DD Tailored Plan's network and the Department or other investigatory agencies have not initiated a payment suspension or withhold.
      - c) The BH I/DD Tailored Plan shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.

- ii. The BH I/DD Tailored Plan shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate recipient enrollment or program/service changes.
- iii. The BH I/DD Tailored Plan shall capture and retain the IP address/location and the user login/user name for all claims submitted via an on-line portal.
- iv. The BH I/DD Tailored Plan shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect.
- v. Any denied claims billed shall be returned to the provider with an explanation for the denial.
- b. BH I/DD Tailored Plan Submission of Claims
  - i. The Department collects and uses BH and I/DD service claims data for many purposes including, but not limited to, Federal reporting, budgeting, services verification, State-funded BH, I/DD, and TBI services quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, and research studies.
  - ii. The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely claims data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with State-funded BH, I/DD, and TBI services.
  - iii. The BH I/DD Tailored Plan shall report all services provided using DMH funding (i.e., not Medicaid) through the NC Tracks claims system (or current State claims system), unless the BH I/DD Tailored Plan chooses to reimburse the provider for an allowable service or support that cannot otherwise be reported as a claim and which must be reported to the State on a non-UCR basis.
  - iv. For services paid for pursuant to UCR-funded methodology, the BH I/DD Tailored Plan shall enroll members into the appropriate benefit plan and report service units to NC Tracks.
  - v. The BH I/DD Tailored Plan shall report the claim through NC Tracks to capture service events regardless if the BH I/DD Tailored Plan does not reimburse providers on a FFS basis (e.g., case rates and other funding methods).
  - vi. The BH I/DD Tailored Plan shall only bill the Department for the amount paid to the provider and shall not bill the state for an amount that exceeds the amount paid to the provider.
  - vii. The BH I/DD Tailored Plan shall ensure that claims submission contains accurate and complete content to allow either (a) claims payment through the appropriate source of non-Medicaid federal funds- not included in single stream funding or (b) processing as shadow claims data that is accepted in NC Tracks (not denied).
  - viii. The BH I/DD Tailored Plan shall adhere to requirements set forth in allocation letters, when such requirements are consistent with terms of the Contract.
  - ix. The BH I/DD Tailored Plan shall be responsible for ensuring all recipients receiving State-funded Services possess a unique identifier that can be used to link and monitor transitions and service use between Medicaid and State-funded Services. The BH I/DD Tailored Plan shall check CNDS for existing identifier assignments prior to assigning a new identifier.
  - x. Submission timeframes
    - a) The BH I/DD Tailored Plan shall submit to NC Tracks an electronic claim for every service reimbursed by the BH I/DD Tailored Plan:
      - 1. Within fifteen (15) Business Days of the close of the month in which the service was paid or processed, or
      - 2. The Department's timely filing deadline for prior year dates of service, whichever comes first.
  - xi. The BH I/DD Tailored Plan shall correct ninety percent (90%) of claim denials in NC Tracks within thirty (30) Calendar Days and ninety five (95%) within forty-five (45) Calendar Days.

- xii. The BH I/DD Tailored Plan shall not be deemed in non-compliance with these standards if the issues cannot be corrected due to issues arising from NC Tracks.
- xiii. The BH I/DD Tailored Plan shall conduct data validation of all data it submits to NC Tracks.

7. Financial Requirements

a. Payment Plan

- i. The Department shall distribute to each BH I/DD Tailored Plan not less than one twelfth (1/12) of each BH I/DD Tailored Plan's Single Stream Fund (SSF) base allocation on a monthly basis, subject to adjustments and availability of funds allocated by the General Assembly for this purpose.
- ii. The Department shall distribute to each BH I/DD Tailored Plan other state funding, special categorical, and federal block grant funds according to the methodology outlined in related allocation letters. BH I/DD must comply with all terms and conditions set forth in related allocation letters.
- iii. The Department shall reimburse BH I/DD Tailored Plans for Non-UCR State Special Categorical funds and Non-UCR Federal funds after the BH I/DD Tailored Plan has expended the funds and reported the expenses on the Financial Status Report (FSR).
- iv. When Non-UCR funding is paid to providers under contract with the BH I/DD Tailored Plan, both the provider and the BH I/DD Tailored Plan must have incurred the expense prior to the BH I/DD Tailored Plan reporting the expenses to the Department.

b. Services Funding

- i. The BH I/DD Tailored Plan shall use State and federal non-Medicaid funds to purchase services included in the State-funded Service array, approved as an alternative service or as specified on the allocation letter.
- ii. Non-UCR Expenditures
  - a) The BH I/DD Tailored Plan may choose to pay for unique services or fund innovative projects using funds that cannot be reported through the UCR/claims methodology
  - b) The BH I/DD Tailored Plan shall submit a non-UCR service request to the Department using the Department's template.
  - c) The Department intends to release further guidance on the UCR/claims methodology prior to BH I/DD Tailored Plan launch.
  - d) The Department shall ensure that non-UCR expenditures meet federal block grant requirements, including MOE.
  - e) If the non-UCR funds are in support of a service that is also eligible to bill through NC Tracks, the BH I/DD Tailored Plan shall assure that the combination of total UCR and non-UCR funding paid is no more than the actual cost of the service provided to State-funded Services recipients.
  - f) For Federal funds and Special Categorical State funds, the BH I/DD Tailored Plan shall submit the Fund Realignment Request Form to move funds from UCR to Non-UCR, with an explanation for the transfer attached.<sup>20</sup>
    - 1. The Department shall issue an approval, denial or a request for more information regarding the Fund Realignment request within fifteen (15) Calendar Days of receipt.
    - 2. If no timely response is received, the BH I/DD Tailored Plan may proceed as if approved.

c. Administrative Funding

- i. The BH I/DD Tailored Plan shall be allowed to expend up to ten percent (10%) of the amount of SSF expended in the prior year on administrative expenses.
- ii. Unless determined otherwise by the Department, the BH I/DD Tailored Plan is responsible for covering administrative costs related to management of the expenditures described in this Section

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<sup>20</sup> This form is also used to move funds between accounts or from Non-UCR to UCR.

within this amount, as well as BH I/DD Tailored Plan functions described more fully in this Scope of Services.

- iii. The BH I/DD Tailored Plan shall provide evidence of all administrative expenditures for each function listed above on the monthly Financial Reporting tool, and, upon request, provide backup documentation including its cost allocation methodology for administrative expenses across Medicaid and State-funded Services.
- d. Changes in Funding
  - i. The Department may adjust the State and federal funding in accordance with the formula used for BH I/DD Tailored Plans.
  - ii. Subject to funding source or other legal requirements, and as determined by the Department the BH I/DD Tailored Plan may, during the term of this Contract:
    - a) In the case of expansion of funding, use up to ten percent (10%) of expansion service funding for administrative expenses.
    - b) In the case of reduced or de-allocated funding, use up to ten percent (10%) of the expended amount for the year for administrative expenses.
  - iii. In the event the Department receives an expansion or reduction in federal block grant funding, allocations to BH I/DD Tailored Plans may be adjusted by the Department in accordance with the requirements set forth by the grant award.
  - iv. The BH I/DD Tailored Plan shall follow the Department's currently approved block grant funding plans, and requirements set forth in the allocation letters.
- e. Disallowances
  - i. Any funds or part thereof transferred by the Department to the BH I/DD Tailored Plan shall be subject to reimbursement by the BH I/DD Tailored Plan to the Department in the event the expenditure of those funds is disallowed pursuant to a State or federal audit.
  - ii. When those funds are disallowed by the Department, the BH I/DD Tailored Plan may recoup those funds back from the provider and the provider shall have no right of appeal.
- f. Settlement Methodology
  - i. The Department shall provide guidance on the settlement process, including required documentation in advance of settlement review. A review will be scheduled upon completion of the BH I/DD Tailored Plan contracted certified external audit and the close of the timely filing deadline each year. The Department shall complete the written report and send to the BH I/DD Tailored Plan within one hundred twenty (120) days after the review is completed. As part of the settlement process:
    - a) The BH I/DD Tailored Plan shall submit all allowable SSF shadow and other UCR claims for the period July 1 through June 30 each fiscal year.
    - b) The BH I/DD Tailored Plan shall submit records of Non-UCR expenses as required by the Department.
  - ii. The BH I/DD Tailored Plan shall supply, in a timely manner, all documentation necessary to complete the settlement process. Failure to provide adequate documentation may result in settlement expenditure disallowances.
  - iii. The Department shall provide preliminary findings to the BH I/DD Tailored Plan in draft report format to provide the BH I/DD Tailored Plan with an opportunity ask questions and provide clarifying information including but not limited to additional documentation to the Department.
  - iv. If the final settlement report indicates that the BH I/DD Tailored Plan must submit a payback of funds, the resolution and appeals process will be conducted in accordance with G. S. 150B.
    - a) If a payback of funds is required, the BH I/DD Tailored Plan shall not use state single stream funding, block grant, or any other State-funded Service dollars to satisfy the payback of funds.
    - b) Contractor shall not reduce services as a result of having to submit any payback of funds.

- v. The BH I/DD Tailored Plan shall cooperate with all financial requirements, monitoring and audits as requested by the Department.
- g. Performance Monitoring
  - i. The BH/IDD Tailored plan shall cooperate with routine performance monitoring and audits, as well as targeted monitoring otherwise required by the Department. The Department shall provide guidance on the routine monitoring process, including required documentation in advance of review.
    - a) The BH I/DD Tailored Plan shall supply, in a timely manner, all documentation necessary to complete the routine or targeted monitoring.
    - b) If a monitoring or performance audit results in findings, refund or corrective action plan, the Department shall provide preliminary findings to the BH I/DD Tailored Plan in draft report format to provide the BH I/DD Tailored Plan with an opportunity ask questions and provide clarifying information including but not limited to additional documentation to the Department.
    - c) Failure to provide adequate documentation may result in expenditure disallowances, corrective action plans, or any other remedies permitted by this document.
  - ii. If the final performance monitoring report indicates that the BH I/DD Tailored Plan must submit a payback of funds or take other actions, the resolution and appeals process will be conducted in accordance with G. S. 150B.
- h. Federal Grant Maintenance of Effort
  - i. The BH I/DD Tailored Plan shall meet or exceed the Department's designated MOE requirements necessary to meet federal grant requirements. Restrictions on the Expenditure of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Funds and Community Mental Health Block Grant (CMHBG or MHBG) Funds
  - ii. The BH I/DD Tailored Plan not use CMHBG and SAPTBG funds to provide or purchase inpatient hospital services, except for SAPTBG funds that may be used as described in 45 CFR 96.135(c).
  - iii. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to make cash payments or allow the purchase of any cash equivalents (e.g., gift cards) for payments to or use by any recipients or intended recipients of BH and I/DD services.
  - iv. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.
  - v. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e., Federal funds may not be used to satisfy any condition for any State, local or other funding match requirement).
  - vi. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to provide financial assistance to any entity other than a public or nonprofit private entity.
  - vii. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds towards the annual salary of any BH I/DD Tailored Plan, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.
  - viii. SAPTBG Restrictions
    - a) The BH I/DD Tailored Plan shall not use SAPTBG funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
    - b) The BH I/DD Tailored Plan shall not use SAPTBG funds to provide individuals with treatment services in penal or correctional institutions of the State.<sup>21</sup>

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<sup>21</sup> This includes jails, prisons, adult and juvenile detention centers and juvenile training centers.

- ix. The BH I/DD Tailored Plan shall not use PATH formula grants funds:
  - a) For inpatient psychiatric treatment costs or inpatient substance abuse treatment costs;
  - b) To support emergency shelters or construction of housing facilities; or
  - c) To make cash payments or allow the purchase of any cash equivalents (e.g., gift cards) for payments to or use by any recipients or intended recipients of BH and I/DD services, except as permitted by 45 CFR § 96.135(a).
- i. Financial Viability
  - i. The BH I/DD Tailored Plan must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C.
  - ii. The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund its BH I/DD Tailored Plan risk reserves at twelve and a half percent (12.5%)<sup>22</sup> of total expected annual BH I/DD Tailored Plan Medicaid capitation.
    - a) If a BH I/DD Tailored Plan fails to meet the Medicaid risk reserve standards outlined in *Section V.B.7.iii.(vii) Financial Viability* by Day 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan must submit a viable plan outlining how the BH I/DD Tailored Plan will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section V.A.1.vi. Readiness Review Requirements*.
  - iii. The BH I/DD Tailored Plan must, by at least ninety (90) days before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-110, contingent upon legislative authority.
  - iv. The BH I/DD Tailored Plan shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current assets include any short-term investments that can be converted to cash within five (5) Business Days without significant liquidated damages. Significant liquidated damages are a liquidated damage greater than twenty percent (20%). Financial reporting should be inclusive of both Medicaid and State funds.
  - v. The BH I/DD Tailored Plan shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as Cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period measured in days. Financial reporting should be inclusive of both Medicaid and State funds.
  - vi. The BH I/DD Tailored Plan shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.
  - vii. The Department may, at its discretion, implement a risk corridor program to provide additional protection to the BH I/DD Tailored Plan to address any uncertainty associated with pricing assumptions and access to additional capital for the BH I/DD Tailored Plan, compared to other commercial plans operating Medicaid Managed Care programs in North Carolina. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.
- 8. Technical Specifications
  - a. Data Exchange Model
    - i. Electronic Data Interchange (EDI) and Other Integrations
      - a) Integrations between the BH I/DD Tailored Plan, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the

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<sup>22</sup> 12.5% of expected annual BH I/DD Tailored Plan capitation is used as a proxy for appropriate Risk Based Capital (RBC) solvency standards. 300% RBC is approximately equal to 1.5 months of claims, or approximately 12.5%.

program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.

- b) The BH I/DD Tailored Plan shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 142.308(d).
  - c) If the BH I/DD Tailored Plan stores, transmits, or maintains data or information in an encrypted format, the BH I/DD Tailored Plan will, at the Department's request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
  - d) The BH I/DD Tailored Plan will work with the Department or its designated Vendor to establish and manage all integration.
  - e) Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the BH I/DD Tailored Plan's ability to deliver recipient services, it must be reported immediately. The BH I/DD Tailored Plan will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at its discretion will track issues reported by the BH I/DD Tailored Plan and may require a more comprehensive corrective action plan if the Department identifies trends in the BH I/DD Tailored Plan's performance.
- ii. Retransmissions
    - a) If the BH I/DD Tailored Plan receives an unintelligible transmission from the Department or Department vendor, the BH I/DD Tailored Plan will immediately notify the Department and the Department shall retransmit as soon as the errors are remediated.
    - b) If the BH I/DD Tailored Plan is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the BH I/DD Tailored Plan shall retransmit as soon as the errors are remediated.
    - c) For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.
  - iii. Test Data Transmission
    - a) The BH I/DD Tailored Plan will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those needed for daily operations. This may include data exchanges between the Department and the BH I/DD Tailored Plan. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.
- b. Service Claims and Eligibility Data
    - i. The BH I/DD Tailored Plan shall have the ability to send and receive the current version of the HIPAA transactions including:
      - a) 834-recipient enrollment and eligibility maintenance
      - b) 835-Remittance advice
      - c) 837I-Institutional claims
      - d) 837P-Professional claims
      - e) 999-Batch acknowledgment for 5010 version
      - f) 270 Eligibility Request

- g) 271 Eligibility Response
  - h) 276 Claim Status Request
  - i) 277 Claim Status Response
  - j) 277U (Unsolicited) Claim Status Response (pending claims)
- c. Provider Identification Numbers (NPIs, APIs)
- i. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the BH I/DD Tailored Plan must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting claims data to the BH I/DD Tailored Plan.
  - ii. The BH I/DD Tailored Plan is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.
  - iii. The BH I/DD Tailored Plan shall include the NPI of the network provider on all claims data that is submitted to the Department.
- d. Provider Directory
- i. The BH I/DD Tailored Plan shall develop a Provider Directory in accordance with *Section V.C.4.b. Provider Network Management*.
    - a) The BH I/DD Tailored Plan should use the National Provider Identifier (NPI) issued by NPPES as the unique provider identifier. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by NC DHHS' NCTracks system should be used.
    - b) The BH I/DD Tailored Plan shall ensure the Provider Directory aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if the BH I/DD Tailored Plan delegates this activity to a Subcontractor
- e. Technology Documents
- i. The BH I/DD I/DD Tailored Plan shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.
  - ii. Security Compliance Plan: The BH I/DD Tailored Plan shall provide a plan that details how the BH I/DD Tailored Plan will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the Security Compliance Plan shall be updated annually and resubmitted to the Department for review. The plan must include at a minimum:
    - a) Approach to recipient data protection including internal programs and policies;
    - b) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
    - c) Approach to complying with HITECH and HIPAA;
    - d) Process and procedures necessary to comply with 42 CFR Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:
      - 1. Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 CFR Part 2; and
      - 2. Where appropriate, secure Member consent prior disclosing member protected health information covered under 42 CFR Part 2 requirements and; establish functionality or procedures to remove or redact information protected by 42 CFR Part 2 prior to disclosure of the information.
    - e) Approach to risk analysis and assessment associate with NIST;
    - f) Processes for monitoring for monitoring for security vulnerabilities including the use of external organization such as US CERT;
    - g) Processes and plans for vulnerability and breach management including response processes; and

- h) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software)
- iii. Claims Implementation Approach. The BH I/DD Tailored Plan shall provide a plan that shows how the BH I/DD Tailored Plan will implement its encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
  - a) Approach to meeting performance, accuracy, and timeliness requirements;
  - b) Operating model including staffing and technology to process and submit encounters;
  - c) Reference data management process including how the State's reference data (if applicable) will be integrated into the encounter management process;
  - d) Change management plan including how changes to the encounter submission infrastructure are tested and implemented; and
  - e) QA and Process improvement processes including how errors detected by the State's Processing System are addressed by the Applicant, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Applicant's processes.
- iv. System Interface Design. The BH I/DD Tailored Plan shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
  - a) Detailed design by interface showing the Applicant's approach to meeting the requirements defined by the State;
  - b) Approach to managing EDI transactions including technology;
  - c) Technical integration architecture including the Applicant's technical approach to integrating multiple internal systems with external partners;
  - d) Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
  - e) Software and platform testing processes for new interfaces including the data management approach.
- v. System Test Plan. The BH I/DD Tailored Plan shall develop and maintain a System Test Plan inclusive of the BH I/DD Tailored Plan's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. The Test Plan shall be submitted to the Department annually at the end of each Contract Year by July 31 and otherwise upon request by the Department and shall include:
  - a) High level description of the scope of each testing phase;
  - b) Applications or Systems that are part of the testing;
  - c) Integrations that are part of the testing;
  - d) Testing techniques or tools that will be used for testing;
  - e) Test environment; and
  - f) Test metrics and reporting of defects.
- f. BH I/DD Tailored Plan Data Management and Health Information Systems
  - i. The following section contains high-level information on Health Information System and recipient data that will be established, maintained, analyzed, and reported by the BH I/DD Tailored Plan:
    - a) The BH I/DD Tailored Plan shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the BH I/DD Tailored Plan 's

operations as well as satisfying the reporting requirements detailed in this RFA which may include but are not limited to utilization, claims, grievances and appeals.

- b) The BH I/DD Tailored Plan shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act.
  - c) The BH I/DD Tailored Plan shall collect and maintain data on recipient and provider characteristics and interactions as specified by the state and on all services furnished to recipients through a claims processing system or other methods as specified by the Department.
  - d) All data, reports, and information submitted by the BH I/DD Tailored Plan on behalf of the Providers (including Providers within or outside of its networks) shall be validated by the BH I/DD Tailored Plan as accurate and complete prior to submission.
  - e) The BH I/DD Tailored Plan shall collect data from Providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
  - f) The BH I/DD Tailored Plan shall make all collected data available to the Department.
  - g) Specific reporting requirements are set for in *Section VII. Attachment J. Reporting Requirements*.
- g. Test Environments
- i. The Contractor shall have at least two (2) dedicated testing environments – one (1) for Systems Integration Testing, and one (1) for End to End testing. The environments shall use the appropriate data sets (production or synthetic) as defined by the Department.
  - ii. The Contractor shall ensure test environments are compliant with all security requirements defined by North Carolina State and the Department’s Privacy and Security Office to support testing with production data.
  - iii. The Contractor shall have test environments available and configured within one hundred twenty (120) days of the Department’s written notice.
  - iv. The Contractor shall have the ability to refresh test environments from production data as needed for testing, as well as the ability and capacity to ingest production sized files with limited to no down time.

## VI. Contract Performance for Medicaid and State-funded Services

### A. Contract Compliance and Performance

1. The Contractor shall comply with all terms, conditions, requirements, performance standards as set forth in the Contract and any amendments thereto, including any rules, policies, or procedures incorporated pursuant to the Contract, as well as all applicable laws and regulations.
2. The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity including but not limited to, remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the Contractor has violated any provision of the Contract, or if the Contractor does not comply with any other applicable North Carolina or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract, which shall include, but may not be limited to the following:
  - a. Fails substantially to provide medically necessary covered services;

- b. Imposes on members and recipients' premiums or cost share that are in excess of the premiums or cost share permitted by the Department;
  - c. Acts to discriminate among members and recipients on the basis of their health status or need for health care services;<sup>23</sup>
  - d. Misrepresents or falsifies information that it furnishes to CMS, SAMHSA, or to the State;
  - e. Misrepresents or falsifies information that it furnishes to a member or recipient, potential member or recipient, or provider;
  - f. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information;
  - g. For Medicaid only:
    - i. Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations;
    - ii. Fails to comply with the requirements for physician incentive plans as required by 42 C.F.R. §§ 422.208 and 422.210; or
  - h. For State-funded Services only:  
Violates any of the other applicable requirements of the Substance Abuse Prevention and Treatment Block Grant, Community Mental Health Services Block Grant, or State law or regulations related State-funded Services.
3. Risk Level Assignment
- a. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or of applicable law (each considered a "Violation"), the Department shall assign the Violation into one of four risk levels:
    - i. **Level 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' or recipients' access to care or services; and/or jeopardize the integrity of Medicaid Managed Care or State-funded Services.
    - ii. **Level 2:** Action(s) or inaction(s) that jeopardize the integrity of Medicaid Managed Care or State-funded Services but does not necessarily jeopardize member(s) or recipients(s) health, safety, and welfare or reduces access to care.
    - iii. **Level 3:** Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid Managed Care or State-funded Services.
    - iv. **Level 4:** Action(s) or inaction(s) that inhibit the efficient operation of Medicaid Managed Care or the provision of State-funded Services.
  - b. The Department's decision to impose specific remedial action(s), intermediate sanction(s) and/or liquidated damages against the Contractor will include consideration of some or all of the following factors:
    - i. Risk Level assignment
    - ii. The nature, severity, and duration of the violation;
    - iii. The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, Program Integrity);
    - iv. Whether the Violation resulted from negligent or willful conduct;
    - v. Whether the violation (or one that is substantially similar) has previously occurred;

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<sup>23</sup> This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3).

- vi. The timeliness in which the Contractor self-reports a violation;
  - vii. The Contractor's history of compliance;
  - viii. The good faith exercised by the Contractor in attempting to stay in compliance (including self-reporting by the Contractor); or
  - ix. Any other factor the Department deems relevant based on the nature of the violation.
  - x. The Department may impose additional remedial actions, intermediate sanctions, or liquidated damages if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.
  - xi. The Department also may elevate the violation to a higher Risk Level if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.
- c. Additional detail on risk level assignment is included in *Section VII. Attachment K. Risk Level Matrix for Medicaid and State-funded Services*.

## B. Notice of Deficiency

1. Except for the appointment of temporary management imposed pursuant to the Contract, the Department shall provide the Contractor with written notice of any remedial action, intermediate sanction, or liquidated damages against the Contractor or termination of the Contract for cause, detailing the nature of the Violation or noncompliance, the risk level assigned to the Violation, any actions the Department seeks to impose against the Contractor, and, if applicable, the method and timeframes by which the Contractor may dispute the claim of the Violation or noncompliance and the imposed actions.
2. Within three (3) Business Days of full remediation of the identified Violation(s) in the Notice of Deficiency, or within another timeframe as requested by the Department, the Contractor shall provide the Department with written notice confirming the date that the Violation or noncompliance was resolved and the actions the Contractor took to remediate the Violation or noncompliance.

## C. Remedial Actions

1. **Remedial Actions:** Prior to the imposition of intermediate sanctions or liquidated damages or contemporaneously with, if the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may require the Contractor to take or to engage in the following remedial actions to address identified violation(s) or other noncompliance:
  - a. Immediate remediation of the Violation or non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the Violation or noncompliance;
  - b. Submission and implementation of a Corrective Action Plan; or
  - c. Participation in additional education or training.
2. **Corrective Action Plans (CAPs):** Contractor shall accept and implement a Department defined CAP or develop a CAP for Department approval as required in this Section.
  - a. Following notification of the original Violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the Violation until an approved CAP is implemented.
  - b. Any CAP required to be submitted by the Contractor shall, at a minimum, identify the following:
    - i. The Violation or finding resulting in a request for corrective action by the Department;
    - ii. A description of how the Violation or finding resulting in a request for corrective action will be remediated;

- iii. The timeline for the implementation and completion of each corrective action(s) included in the CAP; and
    - iv. The name of the responsible person(s) who will lead each of the corrective action activities and the person responsible for the overall implementation of the CAP.
  - c. Any CAP submitted by the Contractor shall be subject to approval by the Department.
  - d. The Contractor shall submit the CAP within fifteen (15) Calendar Days, or another timeframe as determined by the Department depending on the nature of the Violation, from the date of the Notice of Deficiency requiring the CAP.
  - e. Upon receipt, the Department may accept the CAP as submitted, accept the CAP with specified modifications, or reject the CAP.
  - f. If the Department requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP within ten (10) Calendar Days, or, depending on the nature of the violation, within a timeframe determined by the Department that addresses the concerns identified.
  - g. The Contractor shall complete the corrective action(s) contained in the CAP within the time period approved by the Department.
  - h. The Contractor shall provide updates to the Department on the implementation of the CAP and the remediation of the findings resulting in the CAP at the interval requested by the Department.
3. **Effective Date of Remedial Actions**
- a. The effective date for any required remedial action is the date of the written Notice of Deficiency. Any time frames regarding Contractor action will be calculated from the date of the Notice of Deficiency.
  - b. A remedial action is not contestable under the dispute resolution process described in this Section, and the Contractor shall be required to complete the remedial action within the timeframe provided in the Notice of Deficiency, except for a requirement to submit and implement a CAP that shall be completed in accordance with Contract requirements.

## D. Intermediate Sanctions

1. **Imposition:** If the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may impose the following intermediate sanctions against the Contractor:
  - a. Suspension, recoupment, or withholding of payment;
  - b. Suspension of all or part of marketing activities;
  - c. Suspension of part of the Contract;
  - d. Exclusion from participation in Medicaid Managed Care and/or State-funded Services;
  - e. Any other additional sanctions allowed under North Carolina or federal law or regulation; or
  - f. For Medicaid only:
    - i. Civil Monetary Penalties (CMP) in accordance with 42 C.F.R. § 438.704;
    - ii. Appointment of temporary management of the Contractor in accordance with 42 C.F.R. § 438.706(a);<sup>24</sup>
    - iii. Notification to members of their right to terminate their enrollment with the Contractor without cause;
    - iv. Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction;
2. **Effective Date of Intermediate Sanctions**

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<sup>24</sup> If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. Part 438, the Department will notify affected members of their right to terminate enrollment in the Contractor without cause.

- a. If the Contractor elects not to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day following the expiration of the period to dispute or such other date determined by the Department and included in the written Notice of Deficiency.
- b. If the Contractor elects to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day of the date on the written final decision issued by the Department.
- c. The Department shall not be required to delay the appointment of temporary management to provide the Contractor the opportunity to dispute the imposition of the sanction before imposing temporary management. The Department shall not terminate temporary management until it determines that the Contractor can ensure that the noncompliant behavior resulting in the temporary management will not reoccur.

## E. Liquidated Damages

1. If the Contractor is determined by the Department, in its sole discretion, to be in violation with the terms, conditions, requirements, and/or performance standards of the Contract, it is presumed by the Contractor that the Department will be harmed, and the Department shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.
2. The actual damage sustained by the Department as a result of the Contractor's failure to meet the requirements of this Contract will be extremely difficult or impossible to ascertain with precise accuracy. Therefore, the Department and the Contractor agree that if the Contractor is in violation of the terms, conditions, requirements and/or performance standards of the Contract, the Department may assess liquidated damages against the Contractor in accordance with the Contract.
3. Following receipt of a Notice of Deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract until such time as the Department, in its sole discretion, determines the Violation(s) has been cured.
4. The Department, in its sole discretion, reserves the right to assess a general liquidated damage in an amount commensurate with the Violation, as applicable, for any violation not specifically listed in *Section VII. Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*; provided, however, that no violation of any Contract requirement related solely to State-funded Services not specifically listed in *Section VII. Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages* shall exceed on hundred, twenty-five dollars (\$125.00) per day, per occurrence, and/or per member.
5. Liquidated damages assessed by the Department do not affect the Contractor's rights or obligations with respect to any third-party including beneficiaries or providers.

## F. Payment of Liquidated Damages and other Monetary Sanctions

1. If the Contractor elects not to dispute the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within fifteen (15) Calendar Days of the date of the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.
2. If the Contractor elects to dispute the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages or other monetary sanctions shall be due and payable within ten (10) Calendar Days of the date on the written notice of the final decision issued by the Department upholding its original decision to impose the liquidated damages or other monetary sanctions (including a final decision modifying the amount owed).
3. If the Contractor fails to pay liquidated damages or other monetary sanctions by the applicable due date, the Contractor shall be subject to interest and a late payment penalty in accordance with N.C. Gen. Stat. § 147-86.23 and N.C. Gen. Stat. § 105.241.21 until the past due amount is paid.

4. The Department shall reserve the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount (including interest and late payment penalties) from future payments owed to the Contractor. The Department shall provide written notice to the Contractor prior to withholding a portion of the payment for assessed liquidated damages or other monetary sanctions. For Medicaid only, actions taken by the Department to withhold a portion of a capitation payment for assessed liquidated damages or other monetary sanctions shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a).
5. For State-funded Services, the Contractor shall not use state single stream funding, block grant, or any other State-funded Service dollars to pay for the assessed liquidated damage, nor shall Contractor reduce services as a result of having liquidated damages assessed against it to pay for the assessed liquidated damage.

## G. Dispute Resolution for Contract Performance

1. The Contractor shall exhaust the dispute resolution process described in this Section to dispute the imposition of intermediate sanctions, the assessment of liquidated damages, CMPs, and/or for cause termination of the Contract whether pursuant to 42 C.F.R. § 438.708 (for Medicaid Services) or otherwise by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.
2. The Contractor shall have the right to dispute certain contract performance actions by the Department, including the imposition of CAPs, intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the Contractor shall not have the right to dispute the Department's decision to require the Contractor to perform a remedial action.
3. **Dispute Resolution Procedures**
  - a. To initiate a dispute, the Contractor shall submit a written request for a dispute resolution within fifteen (15) Calendar Days of the date of the Notice of Deficiency imposing the Department's intended action. The Department may extend the Contractor's deadline to request dispute resolution for good cause if the Contractor requests an extension within ten (10) Calendar Days of the date on the written notice.
  - b. The Contractor shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
  - c. The Contractor waives any dispute not raised within fifteen (15) Calendar Days of the date of the Notice of Deficiency, unless the Department grants an extension.
  - d. The Contractor also waives any arguments, materials, data, and information it fails to raise in writing within fifteen (15) Calendar Days (unless the Department grants an extension) of the date of the Notice of Deficiency for dispute resolution and in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
  - e. The Department shall review the dispute resolution request and any evidence and information submitted and issue a written final decision within sixty-five (65) Calendar Days of the Contractor's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the Contractor of any extension and the reason for such extension.
  - f. The final decision issued by the Department following dispute resolution shall not be subject to further review or appeal within the Department.
4. **For Medicaid Only: Hearing Prior to Termination of Contract with Cause**
  - a. The Contractor shall be entitled to a hearing only in the event that the Department seeks to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the Termination for Cause Section of the Contract.

- b. At least fifteen (15) Calendar Days prior to the hearing, the Contractor shall receive written notice of the hearing that includes the date, time, place, nature of the hearing, and whether the hearing shall be held in-person or by telephone.
  - c. The hearing may be conducted even if the Contractor fails to appear at the hearing after receiving proper notice.
  - d. At the hearing, the burden shall be on the Contractor to demonstrate that the Department's decision to terminate the Contract with cause pursuant to 42 C.F.R. § 438.708 should be reversed.
  - e. Following the hearing, the Contractor shall receive a written final decision within sixty-five (65) Calendar Days of the date of the scheduled hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, the Contractor shall be notified of the extension and the reason for such extension.
  - f. In a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to the Contractor, and give the Contractor's members and recipients notice of the termination and information, consistent with 42 C.F.R. § 438.10, of their options for receiving Medicaid or State-funded Services after the Contract is terminated.
5. **Legal Representative:** The Department and the Contractor may be represented by legal counsel throughout the dispute resolution process.

## H. Notice to External Agencies

- 1. **For Medicaid Only:** The Department shall provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) Calendar Days after the Department imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.
- 2. The Department shall provide notice as required by law to any other state or federal agency for Violations of the terms, conditions, or requirements of this Contract or applicable laws or regulations by the Contractor.

## I. Publication of Contract Compliance Issues

- 1. The Department may publish on its website on a quarterly basis a list of Contractors subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the risk level assigned to Violation(s), the type of actions imposed on the Contractor, and the basis for the actions taken by the Department.
- 2. The Department shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by the Department.

## J. Right to Waive or Modify

The Department, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor for any good cause as determined by the Department, which includes the right of the Department to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve the underlying Violation that resulted in the action taken by the Department.

## K. Performance Standards and Service Level Agreements

- 1. The Department has established performance standards for the measures listed in Tables 3-5 of *Section VII. Attachment P. Performance Metrics, Services Level Agreements and Liquidated Damages* and corresponding liquidated damages for any performance standard that is not met.
- 2. The Contractor shall meet the requirements of the Contract, including the performance standards and service level agreements specified in *Section VII. Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*.

3. If the Contractor fails to meet any performance standard, the Department may assess liquidated damages as provided in *Section VI. Contract Performance for Medicaid and State-funded Services*, and for Medicaid, impose any other remedial action or intermediate sanction, in accordance with *Section VI. Contract Performance for Medicaid and State-funded Services* for the period in which the deficiency occurs and until the Department, in its sole discretion, determines the deficiency has been cured.

#### **L. Withholds for Medicaid**

1. The BH I/DD Tailored Plan shall participate in the Department's withhold program.
2. The withhold program will conform to 42 C.F.R. § 438.6.
3. The withhold program will be effective eighteen (18) months following the date of BH I/DD Tailored Plan launch, or at a later date as determined by the Department.